71

Supreme Court, U.S.
FILED

No. (D) 07-537 OCT 19 2007

OFFICE OF THE CLERK

In The

Supreme Court of the United States

PARK MANOR, LTD.,

Petitioner,

v.

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

AND

CENTERS FOR MEDICARE
AND MEDICAID SERVICES,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

ROBERT M. HESSLINK, JR.
HESSLINK LAW OFFICES, S.C.
State Bar No. 1013876
Counsel of Record for Petitioner
P.O. Box 930005
Verona, WI 53593-0005
(608) 845-3775

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Is a non-governmental party who prevails in an administrative rule enforcement proceeding thereby barred from obtaining an award of attorneys fees under the "excessive demand" provisions of 5 U.S.C. §504(a)(4)?

2. What legal standard should be applied in determining whether an agency's demand is substantially in excess of the decision and is unreasonable when compared with such decision, within the meaning of 5 U.S.C. §504(a)(4)?

3. Is an agency required to establish that its actions that prompted administrative litigation had a reasonable basis in fact and law in order to avoid an award of the attorneys fees incurred in that proceeding under 5 U.S.C. §504(a)(1) if the agency's actions were designed to advance public health or safety?

4. Is an agency's position substantially justified if some of its position has a reasonable basis in fact and law but the larger portion of it does not?

CORPORATE DISCLOSURE STATEMENT

Park Manor, Ltd. is a Wisconsin corporation. There is no parent corporation. There is no publicly held company that has an ownership interest in Park Manor, Ltd.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
CORPORATE DISCLOSURE STATEMENT	ii
TABLE OF APPENDIX	v
TABLE OF AUTHORITIES	vi
OPINIONS BELOW	1
STATEMENT OF JURISDICTION	1
STATUTES AND REGULATIONS INVOLVED	2
STATEMENT OF THE CASE	2
REASONS FOR GRANTING THE PETITION	8
I. THE CIRCUIT COURT'S INTERPRETATION OF 5 U.S.C. §504(a)(4) WARRANTS REVIEW BY THIS COURT	10
A. Whether Prevailing Litigants Should Be Barred From Recovering Under 5 U.S.C. §504(a)(4) Is An Important Issue Of Federal Law That Should Be Settled By This Court	11
B. The Decision Of The Seventh Circuit Is Based On A Standard For Determining When A Demand Is Excessive That Does Not Represent The Only Reasonable Construction Of 5 U.S.C. §504(a)(4)	17

TABLE OF CONTENTS – Continued

Page

II. THE HOLDING THAT AN AGENCY WHICH ENFORCES PUBLIC HEALTH OR SAFETY REQUIREMENTS CAN BE RELIEVED OF ITS OBLIGATION TO PROVE THAT ITS PRE-LITIGATION POSITION WAS SUBSTANTIALLY JUSTIFIED WARRANTS REVIEW 20

A. The Creation Of A Separate Standard Of Reasonableness For Agencies Which Regulate In The Areas Of Public Health Or Safety Should Only Be Done After A Thorough Review By This Court..... 23

B. The Circuit Court's Holding That CMS Is Not Required To Investigate Prior To Imposing Remedies Is In Apparent Conflict With Principles Established By A Decision Of Another Circuit Court..... 27

III. THE DAB'S CONCLUSION, THAT AN AGENCY'S POSITION IS SUBSTANTIALLY JUSTIFIED IF SOME ALLEGATIONS HAVE A REASONABLE BASIS IN FACT AND LAW BUT THE LARGER PORTION DOES NOT, CONFLICTS WITH DECISIONS OF OTHER CIRCUIT COURTS..... 29

CONCLUSION 32

TABLE OF APPENDIX

Page

Opinion of the United States Court of Appeals for the Seventh Circuit Decided July 23, 2007 ..... App. 1

December 16, 2005 Decision of the Departmental Appeals Board Presiding Board Member Judith A. Ballard and Board Members Cecilia Sparks Ford and Donald F. Garrett, Decision No. 2005 ..... App. 9

March 31, 2006 Addendum to Decision No. 2005 of the Departmental Appeals Board Presiding Board Member Judith A. Ballard and Board Members Cecilia Sparks Ford and Donald F. Garrett ..... App. 135

June 17, 2004 Decision of the Departmental Appeals Board Presiding Board Member Judith A. Ballard and Board Members Cecilia Sparks Ford and Donald F. Garrett, Decision No. 1926 ..... App. 157

5 U.S.C. §504 ..... App. 177

45 C.F.R. §13.1 ..... App. 183

45 C.F.R. §13.2 ..... App. 183

45 C.F.R. §13.3 ..... App. 184

45 C.F.R. §13.4 ..... App. 185

45 C.F.R. §13.5 ..... App. 187

45 C.F.R. §13.6 ..... App. 190

TABLE OF AUTHORITIES

Page

CASES

Air Transp. Ass'n of Can. v. Fed. Aviation Admin., 156 F.3d 1329 (D.C. Cir. 1998) 30, 31

Alphin v. Nat'l Transp. Safety Bd., 839 F.2d 817 (D.C. Cir. 1988) 30

American Wrecking Corp. v. Sec'y of Labor, 364 F.3d 321 (D.C. Cir. 2004) 12, 13, 14

Baldi Bros. Constructors v. U.S., 52 Fed. Cl. 78 (2002) 22

Clermont Nursing and Convalescent Ctr. v. CMS, DAB No. CR1087, 2003 WL 22326547 (HHS) (09/25/03) 24

Commissioner, I.N.S. v. Jean, 496 U.S. 154 (1990) 8, 9, 26, 27, 29

Community Hosp. of Long Beach v. CMS, DAB No. 1938 (08/18/04), 2004 WL 2102876 (HHS) 24

Contractor's Sand and Gravel, Inc. v. Federal Mine Safety and Health Review Comm'n, 199 F.3d 1335 (D.C. Cir. 2000) 23, 27, 28

Delta Air Lines, Inc. v. August, 450 U.S. 346 (1981) 15, 16

Donovan v. Dialamerica Marketing, Inc., 757 F.2d 1376 (3rd Cir. 1985) 21

Dougherty v. Lehman, 711 F.2d 555 (3rd Cir. 1983) 20

Enerhaul, Inc. v. N.L.R.B., 710 F.2d 748 (11th Cir. 1983) 21

TABLE OF AUTHORITIES – Continued

Page

EuroPlast, Ltd. v. N.L.R.B., 33 F.3d 16 (7th Cir. 1994) 21

F.J. Vollmer Co., Inc. v. Magaw, 102 F.3d 591 (D.C. Cir. 1996) 21

Hanover Potato Prod., Inc. v. Shalala, 989 F.2d 123 (3rd Cir. 1993) 30

Harmony Court v. CMS, DAB Dec. No. 1968 (2005), Medicare and Medicaid Guide (CCH) ¶ 120803, 2005 WL 835751 ..... 24, 25

Iowa Express Distribution, Inc. v. N.L.R.B., 739 F.2d 1305 (8th Cir. 1984) 21, 26

KMS Fusion, Inc. v. U.S., 39 Fed. Cl. 593 (1997) 21

Marcus v. Shalala, 17 F.3d 1033 (7th Cir. 1994) 21, 23

Mobil Oil Exploration & Producing Southeast, Inc. v. United Distribution, 498 U.S. 211 (1991) 11

Park Manor, Ltd. v. U.S. Dept. of Health and Human Services, 495 F.3d 433 (7th Cir. 2007) 1

Park Manor Nursing Home v. Centers for Medicare & Medicaid Services, DAB No. 2005 (2005), 2005 WL 3753088 (HHS) 1

Park Manor Nursing Home v. Centers for Medicare & Medicaid Services, DAB No. 1926 (2004), Med & Med GD (CCH) ¶ 120676, 2004 WL 1764725 (HHS) 1

Pennsylvania Dep't of Public Welfare v. Davenport, 495 U.S. 552 (1990) 11

TABLE OF AUTHORITIES – Continued

Page

Pettyjohn v. Chater, 888 F. Supp. 1065 (D.C. Colo. 1995) 22

Phil Smidt & Son, Inc. v. N.L.R.B., 810 F.2d 638 (7th Cir. 1987) 21

Pierce v. Underwood, 487 U.S. 552 (1988) 8, 9, 20, 22

Prod. & Maint. Employees' Local 504 v. Roadmaster Corp., 954 F.2d 1397 (7th Cir. 1992) 20

Roanoke River Basin Ass'n v. Hudson, 991 F.2d 132 (4th Cir. 1993) 21

Sec'y of Labor v. Wolkow Braker Roofing Corp., 19 O.S.H. Cas. (BNA) 1267, 2000 O.S.H.D. (CCH) ¶32199, 2000 WL 1466087 ..... 13, 14

Sec'y of Labor, Mine Safety and Health Administration (MSHA) v. L & T Fabrication & Constr., Inc., 22 FMSHRC 509, 2000 O.S.H.D. (CCH) ¶32092, 2000 WL 687693 (F.M.S.H.R.C.) 9, 18

U.S. v. Hallmark Constr. Co., 200 F.3d 1076 (7th Cir. 2000) 21

U.S. v. One 1997 Toyota Land Cruiser, 248 F.3d 899 (9th Cir. 2001) 13, 14

U.S. v. Jones, 125 F.3d 1418 (11th Cir. 1997) 30

STATUTES AND REGULATIONS

5 U.S.C. §504 ..... 2, 22

5 U.S.C. §504(a)(1) ..... *passim*

5 U.S.C. §504(a)(2) 2

TABLE OF AUTHORITIES – Continued

Page

5 U.S.C. §504(a)(4) ..... *passim*

5 U.S.C. §504(b)(1)(E) 20, 23, 25, 26

5 U.S.C. §504(c)(2) 2

28 U.S.C. §1254(1) 1

28 U.S.C. §2412(d)(1)(A) 8

28 U.S.C. §2412(d)(1)(D) 13, 14

42 U.S.C. §§1320a-7a(e) 2

42 C.F.R. §483.151 4

42 C.F.R. §488.308 2

42 C.F.R. §488.331 3

45 C.F.R. §13.1 2

45 C.F.R. §13.2 2

45 C.F.R. §13.3 2

45 C.F.R. §13.4 2

45 C.F.R. §13.5 2

45 C.F.R. §13.5(b) 11

45 C.F.R. §13.6 2

OTHER AUTHORITIES

Fed. R. Civ. P. 68 15

Pub. L. No. 104-121, 110 Stat 847 8

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit is reported at *Park Manor, Ltd. v. U.S. Dept. of Health and Human Services*, 495 F.3d 433 (7th Cir. 2007). (App. 1)

The Seventh Circuit affirmed decisions of the Department of Health and Human Services Departmental Appeals Board. The primary decision is *Park Manor Nursing Home v. Centers for Medicare & Medicaid Services*, DAB No. 2005 (2005), 2005 WL 3753088 (HHS). (App. 9) The DAB's supplemental decision dated March 31, 2006 is unreported. (App. 135)

The decision on the merits of the case by the Departmental Appeals Board is *Park Manor Nursing Home v. Centers for Medicare & Medicaid Services,* DAB No. 1926 (2004), Med & Med GD (CCH) ¶120676, 2004 WL 1764725 (HHS). (App. 157)

STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. §1254(1) to review the circuit court's decision on a writ of certiorari. This case seeks review of the final decision of the Court of Appeals for the Seventh Circuit affirming a decision of the Department of Health and Human Services Departmental Appeals Board (DAB) on an application for attorneys fees under the Equal Access to Justice Act. The DAB had

jurisdiction over the fee claim under 5 U.S.C. §504(a)(2). The circuit court had jurisdiction to review the agency decisions under 5 U.S.C. §504(c)(2) and 42 U.S.C. §§1320a-7a(e). The circuit court's decision was issued on July 23, 2007.

STATUTES AND REGULATIONS INVOLVED

The statute involved in this case is 5 U.S.C. §504, the Equal Access to Justice Act and, because it is lengthy, it is printed verbatim in the appendix at pages 177-182. The regulations involved are 45 C.F.R. §§13.1-13.6, which are also printed verbatim in the appendix at pages 183-191.

STATEMENT OF THE CASE

42 C.F.R. §488.308 requires that all nursing homes who provide services to Medicare eligible individuals be surveyed at least annually to determine if they are being operated in compliance with federal requirements. The Department of Health and Human Services (HHS) contracts with a state agency in Wisconsin to conduct these surveys of Wisconsin nursing homes on HHS's behalf. Centers for Medicare and Medicaid Services (CMS) administers this program within HHS.

Following a March 2001 annual survey, the state survey agency issued a 123-page statement of deficiency (SOD) to Park Manor, a Wisconsin nursing home. That SOD alleged 22 deficiencies, or failures to comply with federal requirements. Six deficiencies alleged actual harm to residents and one alleged a situation of immediate jeopardy (IJ), the most severe form of deficiency. A substandard care allegation immediately suspended Park Manor's nurse aide training and competency evaluation program (NATCEP) for two years. CMS approved all of these recommended findings by the state survey agency and imposed the NATCEP suspension, a $12,400 civil money penalty (CMP) for the IJ, and a continuing CMP of $250 per day for the other alleged deficiencies.

Following a June 2001 verification visit (VV), the state agency recommended, and CMS approved, six additional deficiencies, including one that was a "repeat" of a deficiency cited in the March survey. CMS then imposed the remedy of a suspension of reimbursement for new admissions, and it continued the accrual of the daily CMPs. Park Manor timely appealed all of these deficiencies and remedies.

The IJ and substandard care determinations, and a number of the alleged deficiencies, were dismissed in informal dispute resolution (IDR) proceedings while the appeal process was pending.[1] This dismissal

[1] IDR proceedings represent an opportunity for a facility to informally dispute survey findings. 42 C.F.R. §488.331.

caused the $12,400 CMP for the IJ to be set aside. Following a subsequent VV which found Park Manor in substantial compliance, the amount of the daily CMP imposed by CMS for the remaining deficiencies was set at $250 per day for 124 days, or $31,000.

The ALJ issued a prehearing order which required each party to disclose the evidence it had to support its position(s). CMS elected to go forward to hearing with six deficiencies from the initial survey and one from the VV and it reduced its demand for a CMP to $150 per day. Two of those seven deficiencies were subsequently dismissed on Park Manor's motion for summary disposition, including the only remaining VV deficiency. That ruling set aside the suspension of reimbursement for new admissions. It also reduced the number of days on which a daily CMP could be imposed to the days between the date of the survey and the date of the June VV.

After an evidentiary hearing on the remaining five allegations, the ALJ upheld that daily CMP. His decision was based on one deficiency, an alleged failure to consult with a doctor concerning a significant change of condition. The ALJ concluded that this one deficiency was sufficient to sustain the remaining remedy. Since the total amount of the CMP was greater than $5,000, the NATCEP suspension was also upheld. See 42 C.F.R. §483.151. The ALJ's decision did not address the remaining four deficiencies, which had been alleged at a lesser degree of seriousness.

On review, the DAB dismissed the physician consultation deficiency. It concluded that CMS and the ALJ had misapplied the regulations and that there was undisputed evidence that the changes at issue had occurred before Park Manor's previous report to the physician and the resident wanted comfort measures only. It also concluded that CMS had failed to make a prima facie case on the potential for more than minimal harm, one of the required elements necessary to show a lack of substantial compliance. (App. 158) All of the remaining enforcement remedies imposed by CMS were set aside. *Id.*

The DAB chose to dismiss all the remedies, rather than address or remand the remaining allegations to the ALJ for a determination. It did so, in part, because all were at a level of seriousness such that CMS would not have been required to impose any remedy if they were the only findings CMS had made in the first instance. (App. 174-176) It also found that CMS had not continued to pursue those deficiencies beyond the ALJ level. CMS's motion for a rehearing on this issue was denied.

Park Manor then applied for attorneys fees and costs under the Equal Access to Justice Act (EAJA), basing its application on both 5 U.S.C. §§504(a)(1) and (4). In responding to that motion, CMS did not present any evidence in support of either the facts or the legal theories for the 21 deficiencies which it had alleged and which were either dismissed in IDR or which it had elected not to pursue. It contended only that it was entitled to reasonably rely on the

allegations made in the SODs. The ALJ denied the fee applications in their entirety without addressing these 21 deficiencies.

The DAB partially reversed the ALJ's complete denial of fees but concluded that, with the exception of one VV cite and its attendant remedies (the VV cite dismissed on summary disposition), the position of CMS was substantially justified. (App. 11) In doing so, it adopted CMS's arguments that its position was substantially justified if there were some deficiencies sufficient to support a remedy that were reasonably supported by the facts and law, regardless of whether the remainder were not. The DAB also held CMS was entitled to rely upon the allegations in the SODs themselves and no further evidence of reasonableness was necessary.

In determining that CMS's position was substantially justified with respect to the physician notification deficiency which it had previously dismissed, the DAB concluded that CMS was justified in relying on the allegations in the SOD, even though at the hearing it provided no evidence supporting many of these factual allegations. (App. 59-63) ("CMS had a reasonable basis in fact for its initial determination, relying in part on these findings in the SOD. . . .") (App. 59)

The DAB concluded that Park Manor was not entitled to a fee award under §504(a)(4) because "CMS did not obtain any part of its initial demand," and the provisions of §504(a)(4) were unavailable to

provide relief to prevailing parties. (App. 126) After directing Park Manor to allocate its fees between the claim found not to be substantially justified and the other claims, it awarded Park Manor a small portion of the fees which it had originally sought under §504(a)(1). (App. 156)

On a petition for review, the Seventh Circuit Court of Appeals affirmed the decision of the DAB. It concluded that CMS had no obligation to demonstrate that its initial positions in approving the SODs and imposing the remedies had a reasonable basis in fact and law. It reasoned that requiring CMS to verify the facts and legal theories upon which the SODs were based prior to approving them and imposing remedies would undermine the efficiency of the survey procedures and "retard the correction of the deficiencies found by the state agency." (App. 6)

That court also concluded that allowing prevailing litigants to recover under the excessive demand theory of §504(a)(4) was contrary to the purpose of EAJA because it would undermine the substantial justification analysis embodied in §504(a)(1). (App. 7-8) Embodied in that holding was the conclusion that, unless barred from applying, a prevailing party would automatically qualify for fees under §504(a)(4) because the amount of the agency's demand that it would have recovered would be zero.

REASONS FOR GRANTING THE PETITION

This Court has twice before had occasion to construe the EAJA in *Pierce v. Underwood*, 487 U.S. 552 (1988) and *Commissioner, I.N.S. v. Jean*, 496 U.S. 154 (1990). In both of those cases, the Court construed the EAJA provisions which are applicable to court proceedings, 28 U.S.C. §2412(d)(1)(A), rather than those governing administrative proceedings. This case would provide the Court with an opportunity to address those EAJA provisions which are incorporated in the Administrative Procedure Act (APA). It would also provide the Court with an opportunity to construe the 1996 amendments, Pub. L. No. 104-121, 110 Stat 847, 862-863, which expanded the basis for recovery of fees to include, not only cases in which the government's position on the merits was not substantially justified, but also where the government seeks a penalty that is unreasonable when compared to the final result.

EAJA is designed to provide a climate of fairness in which federal agencies and officers will make their decisions. 5 U.S.C. §§504(a)(1) and (4) are designed to insure that federal agencies who enforce federal requirements will base their decisions on a reasonable factual and legal basis and that they do not seek unreasonable penalties in code enforcement proceedings. Since government positions that are not reasonably based on fact or law, or which seek excessive penalties, are those most likely to be challenged, the ultimate result of a fully effective EAJA would therefore be a reduction in the amount of litigation.

This Court should grant this petition for certiorari in order to address and resolve four important questions involving the interpretation of EAJA that, unless resolved, are likely to recur in administrative proceedings in the future. This case squarely presents the question of whether an administrative litigant who prevails in an administrative enforcement proceeding should be thereby barred from recovering its attorneys fees and costs under the excessive demand provisions, 5 U.S.C. §504(a)(4). The Seventh Circuit's holding that the provisions of §504(a)(4) are unavailable to a prevailing party also rests on its implied holding that eligibility for fees under §504(a)(4) is governed exclusively by a single quantitative analysis which compares the demand to the result. This implied holding conflicts with the two-part test developed in *Sec'y of Labor, Mine Safety and Health Administration (MSHA) v. L & T Fabrication & Constr., Inc.*, 22 FMSHRC 509, 2000 O.S.H.D. (CCH) ¶32092, 2000 WL 687693 (F.M.S.H.R.C.).

This case also squarely presents the question, not addressed in *Pierce v. Underwood*, *supra*, of whether an agency's duty to fairly evaluate whether its actions which lead to litigation are reasonable in law and fact can be abrogated when the agency's mission includes the protection of public health or safety. Finally, though not addressed by the circuit court, this case presents the question left unanswered in *Commissioner, I.N.S. v. Jean*, *supra*, of whether a position that is substantially justified, in part, can serve as a basis for a fee award under 5 U.S.C. §504(a)(1).

I. THE CIRCUIT COURT'S INTERPRETATION OF 5 U.S.C. §504(a)(4) WARRANTS REVIEW BY THIS COURT.

The excessive demand provisions of EAJA were adopted as part of the 1996 amendments, and have never before been construed or addressed by this Court. The excessive demand provisions of EAJA included in the APA are contained in 5 U.S.C. §504(a)(4). They provide that, in a proceeding in which an agency seeks to enforce a statute or administrative rule and the penalty it seeks to impose was unreasonable when compared to the result, the target of the proceeding can recover the attorneys fees associated with defending against the excessive penalty.

This case presents two distinct issues concerning the interpretation of 5 U.S.C. §504(a)(4) that are worthy of this Court's review. First, is a party who prevails in the enforcement proceeding foreclosed from relief under §504(a)(4) and limited to relief under §504(a)(1) [the substantial justification standard], regardless of whether the penalties sought to be imposed would otherwise be considered excessive? Second, what is the proper test for the agencies and the courts to apply in determining whether the penalties sought by the agency were, in fact, excessive?

A. Whether Prevailing Litigants Should Be Barred From Recovering Under 5 U.S.C. §504(a)(4) Is An Important Issue Of Federal Law That Should Be Settled By This Court.

The Seventh Circuit held that the reach of 5 U.S.C. §504(a)(4) is confined "to the case in which the government prevails but the relief it obtains is meager in comparison to the relief it had sought." (App. 7) It based this conclusion upon a belief that allowing prevailing litigants to get a second bite at the same apple would undercut the "substantially justified" standard set out in 5 U.S.C. §504(a)(1). *Id.* This holding was grounded on policy considerations, rather than upon the language of the statute itself. If allowed to stand without review, such a holding could result in a substantial narrowing of the scope of §504(a)(4).

The primary guide in construing a statute or rule is normally its plain language. "[S]tatutory interpretation begins with the language of the statute itself." *Pennsylvania Dep't of Public Welfare v. Davenport*, 495 U.S. 552, 557-58 (1990) and *Mobil Oil Exploration & Producing Southeast, Inc. v. United Distribution*, 498 U.S. 211, 223 (1991). Neither 5 U.S.C. §504(a)(4) nor 45 C.F.R. §13.5(b), the rule which applies it to DAB cases, contain any language which would limit their reach to non-prevailing parties. Section 504(a)(4) states that:

> If, in an adversary adjudication arising from an agency action to enforce a party's compliance with a statutory or regulatory requirement, the demand by the agency is substantially in excess of the decision of the adjudicative officer and is unreasonable when compared with such decision, under the facts and circumstances of the case, the adjudicative officer *shall* award to the party the fees and other expenses related to defending against the excessive demand. . . .

(Emphasis added.)

In addition, §§504(a)(1) and (a)(4) appear to direct themselves to different potential administrative abuses. Section (a)(1) addresses agency positions that are not substantially justified. Section (a)(4) addresses demands for penalties in code enforcement actions that are excessive. These two scenarios are not necessarily mutually exclusive. Agencies can, and often do, litigate cases in which they take positions that are both not substantially justified *and* seek penalties that are unreasonable and excessive. Absent the Seventh Circuit's policy concerns, subsections (a)(1) and (a)(4), on their face, would appear to allow a successful litigant to pursue either or both theories in an appropriate case.

Section 504(a)(4) does not have the significant history of interpretation by the courts that §504(a)(1) enjoys. The only other circuit court decision dealing with the excessive demand provisions of the EAJA, *American Wrecking Corp. v. Sec'y of Labor*, 364 F.3d

321 (D.C. Cir. 2004), interpreted the language of 28 U.S.C. §2412(d)(1)(D), not 5 U.S.C. §504(a)(4).

Though the court below relied on *American Wrecking Corp.* and the two decisions are not inconsistent, an analysis of the existing legal authority on which the *American Wrecking Corp.* court relied shows that its analysis of the issue was not extensive. By the point in its analysis where the *American Wrecking Corp.* court was deciding whether to apply §2412(d)(1)(D), it had already approved an award of fees based on the lack of substantial justification for the government's position. *Id.* at 327-328. The circuit court then went on to conclude that the excessive demand provision did not permit the recovery of a *larger* award than the litigant was entitled to under the substantial justification standard. *Id.*

This statement in *American Wrecking Corp.*, which appears in the decision almost as an afterthought, is simply stated in terms of the court's inability to "imagine Congress to have intended" such a result, *id.* at 328, followed by citation to *U.S. v. One 1997 Toyota Land Cruiser*, 248 F.3d 899, 904 (9th Cir. 2001) and *Sec'y of Labor v. Wolkow Braker Roofing Corp.*, 19 O.S.H. Cas. (BNA) 1267, 2000 O.S.H.D. (CCH) ¶32199, 2000 WL 1466087. Neither of these two decisions cited as authority in *American Wrecking Corp.*, however, adopted the proposition for which the *American Wrecking Corp.* court cited them.

In *Toyota Land Cruiser*, the issue was whether fees under 28 U.S.C. §2412(d)(1)(D) could be awarded

where the case had settled prior to judgment. The issue of whether a party could recover fees based on an excessive demand theory when the government did not obtain any relief was not in the case. In concluding that the claimant was entitled to fees, the Ninth Circuit Court merely acknowledged that "(d)(1)(D) awards fees to parties against whom the United States obtains a judgment, with no exception for substantial justification." 248 F.3d at 904. The court did not conclude, because it was not called upon to conclude, that fees were not obtainable on an excessive demand theory where the government had been totally unsuccessful on the merits.

Wolkow can be fairly construed to hold that being a prevailing party is *not* a bar to recovery under 5 U.S.C. §504(a)(4). After a review of the legislative history, *Wolkow* concluded that "the test for attorney fees under 504(a)(4) requires a showing that the demand by the Agency *taken as a whole* was unreasonable in relation to the final outcome *taken as a whole without regard as to which litigant was the prevailing party.*" *Sec'y of Labor v. Wolkow Braker Roofing Corp.*, *supra*, at 5. (Emphasis in original and added.)

The precedent from which the *American Wrecking Corp.* holding is derived is therefore less than clear and compelling. If anything, these cases demonstrate that the lower courts and agencies are struggling to come to grips with a relatively new addition to a statute which has yet to be definitively construed

by this Court. A decision on this issue by this Court would therefore provide needed guidance to the lower courts and administrative agencies forced to address attorneys fee requests under the 1996 amendments.

Accepting review would also allow this Court to fully explore the policy considerations upon which the Seventh Circuit's decision rests. Those considerations, while stated, were neither fully analyzed nor based on fully accurate assumptions. The circuit court's "second bite at the same apple" analogy (App. 7), for example, is not a totally accurate portrayal of the relief available to a prevailing litigant under §504(a)(4). To the extent that §504(a)(4) may provide a prevailing party with a second bite at all, it would usually be a bite of a smaller, rather than the same, apple. While §504(a)(1) provides for the recovery of all reasonable fees incurred, §(a)(4) only provides for a recovery of fees "related to defending against the excessive demand."

The circuit court also reasoned that the purpose of §504(a)(4) is "parallel ... to Rule [FRCP] 68" because it "penalizes the greedy winning plaintiff but is inapplicable if the defendant wins." (App. 7-8) In support of this analogy, the court cited this Court's decision in *Delta Air Lines, Inc. v. August*, 450 U.S. 346 (1981). In effect, the circuit court extended *Delta Air Lines* and the rationale underlying Rule 68 into an administrative proceeding in which the fee request is not based upon a refused settlement offer.

The holding in *Delta Air Lines* was based upon this Court's reading of the clear language of Rule 68, which limited its scope to a situation in which the defendant had lost on the merits. ("[T]he words 'judgment . . . obtained by the offeree' – rather than words like 'any judgment' . . . confines its effect to" a case in which the offeror lost on the merits. 450 U.S. at 351. Section 504(a)(4), in contrast, uses the more general term "decision," which does not connote either a win or a loss for the moving party. Whether this Court's holding in *Delta Air Lines*, which was based on the clear language of a procedural rule designed to encourage settlement, should be extended to govern the construction of a statute which is designed to encourage parties to vindicate their rights, and which contains language much less suggestive of a similar result, is an issue that should best be resolved by this Court.

Accepting review would also allow this Court to address a policy concern that the Seventh Circuit did not address in its opinion. Should an agency be liable under §504(a)(4), where it takes a legally and factually *correct* position, but makes an excessive demand for a remedy, but not be so liable where it made that same excessive demand, and based it on a position that was legally and/or factually *incorrect* (but not so incorrect as to not be substantially justified)? A "yes" answer to this question is, in fact, one of the practical effects of the Seventh Circuit's construction of 5 U.S.C. §504(a)(4).

Given the absence of any statutory language which appears to limit the scope of §504(a)(4) in the manner suggested by the Seventh Circuit, such a substantial narrowing of a remedial statute for policy reasons should only be done after careful review by this Court, if at all. This Court should therefore grant the petition for certiorari to determine if a potential avenue of relief under §(a)(4) does exist for prevailing parties.

B. The Decision Of The Seventh Circuit Is Based On A Standard For Determining When A Demand Is Excessive That Does Not Represent The Only Reasonable Construction Of 5 U.S.C. §504(a)(4).

In reaching its conclusion that allowing fee recoveries under §504(a)(4) would undercut the "substantially justified" standard of §(a)(1), the Seventh Circuit also necessarily concluded that, absent such a holding, losing on the merits would automatically trigger a finding that any demand for relief was substantially in excess of the decision and unreasonable, because the agency would have recovered no relief at all. (App. 7-8) The Seventh Circuit therefore, in effect, held that fee awards under §(a)(4) are governed by a single quantitative test in which the final result is mathematically compared to the demand.

While not in conflict with any other circuit court decisions on this point, this holding is in apparent

conflict with another published, and plausible, interpretation of §(a)(4). *Sec'y of Labor, Mine Safety and Health Administration (MSHA) v. L & T Fabrication & Constr., Inc., supra.* The two-part test adopted by MSHRC is also traceable to the language of §504(a)(4), which indicates that fees are recoverable when the demand was "*unreasonable when compared with such decision . . . under the facts and circumstances of the case. . . .*" 22 FMSHRC at 513. (Emphasis in original.)

In *L & T Fabrication & Constr., Inc.*, the Federal Mine Safety and Health Review Commission, after a careful analysis of the statutory language and legislative history of §504(a)(4), concluded that the 1996 amendments to EAJA "set forth a two-part test for determining whether fees should be awarded." *Id.* at 514. The first part of the test is a purely quantitative analysis – a mathematical comparison of the results with the demand. The second part of the test, however, is qualitative. It consists of an individual factual analysis to determine if the administrative decision-maker acted reasonably under the circumstances in setting the penalty to be sought.

While the *L & T* two-part test might make recovery more difficult for some litigants, it also directly undercuts the entire premise upon which the Seventh Circuit concluded that it was necessary to limit the availability of §504(a)(4) to non-prevailing litigants. For, if a win on the merits does not automatically translate to a finding that any penalty that was sought was excessive, the substantial justification

analysis under §504(a)(1) would not be undermined by allowing prevailing parties to seek relief under it, as the Seventh Circuit feared.

The Seventh Circuit, however, undertook no analysis to determine what the actual standard of recovery under §504(a)(4) is. It simply assumed that any litigant who won on the merits would automatically qualify for a fee award under §(a)(4) unless they were disqualified at the outset.[2]

This Court should grant the petition for certiorari because the circuit court's decision and reasoning below could lead to the adoption by the courts of the single quantitative test under 5 U.S.C. §504(a)(4), in preference to the two-part test, without a thorough appellate court analysis of the two alternatives.

---

[2] The circuit court decision suggests that Park Manor had argued for the one-part test. In fact, Park Manor had argued in its reply brief that

> while §(a)(4) does not provide for a fee award 'based solely on the absolute disparity between the initial demand and the outcome . . . ,' as DAB concluded in finding it inapplicable . . . the disparity between the final result and the initial demand is one major factor the decision maker must consider in determining whether a fee award is appropriate.

II. THE HOLDING THAT AN AGENCY WHICH ENFORCES PUBLIC HEALTH OR SAFETY REQUIREMENTS CAN BE RELIEVED OF ITS OBLIGATION TO PROVE THAT ITS PRE-LITIGATION POSITION WAS SUBSTANTIALLY JUSTIFIED WARRANTS REVIEW.

In *Pierce v. Underwood*, 487 U.S. 552 (1988), this Court determined that the standard of "substantially justified" as set forth in EAJA requires that the position of the agency must be "justified to a degree that would satisfy a reasonable person." 487 U.S. at 553. The Court likened this standard to the "reasonable basis both in law and fact" standard which had been adopted by the lower court in that case. *Id.* Substantially justified means more than just not frivolous. *Pierce v. Underwood*, *supra*, *Prod. & Maint. Employees' Local 504 v. Roadmaster Corp.*, 954 F.2d 1397, 1404 (7th Cir. 1992); and *Dougherty v. Lehman*, 711 F.2d 555, 563 (3rd Cir. 1983).

Under the language of EAJA, the agency's "position" encompasses both its pre-litigation actions which prompted the litigation and the positions it takes after the litigation has commenced. (" '[P]osition of the agency' means, in addition to the position taken by the agency in the adversary adjudication, the action or failure to act by the agency upon which the adversary adjudication is based; . . . .") 5 U.S.C. §504(b)(1)(E).

Both before and since *Pierce v. Underwood* was decided, courts have held that, to avoid a fee award

under 5 U.S.C. §504(a)(1), both the agency's litigation positions and its actions leading up to the litigation must be substantially justified. *U.S. v. Hallmark Constr. Co.*, 200 F.3d 1076, 1081 (7th Cir. 2000); *KMS Fusion, Inc. v. U.S.*, 39 Fed. Cl. 593, 597 (1997); *F.J. Vollmer Co., Inc. v. Magaw*, 102 F.3d 591, 595-596 (D.C. Cir. 1996); *Marcus v. Shalala*, 17 F.3d 1033, 1036 (7th Cir. 1994); and, *Iowa Express Distribution, Inc. v. N.L.R.B.*, 739 F.2d 1305, 1309 (8th Cir. 1984). A prevailing party may recover its fees and expenses under EAJA "where the government's prelitigation conduct was not substantially justified even though its litigating position may have been substantially justified and vice versa." *Marcus*, 17 F.3d at 1036 and *Hallmark*, 200 F.3d at 1080-81.

Once a prevailing party moves for fees under EAJA, "the government bears the burden of proving that its position was substantially justified." *Marcus v. Shalala*, *supra*; *KMS Fusion, Inc. v. U.S.*, *supra*; *Roanoke River Basin Ass'n v. Hudson*, 991 F.2d 132, 138-139 (4th Cir. 1993); *Donovan v. Dialamerica Marketing, Inc.*, 757 F.2d 1376, 1389 (3rd Cir. 1985); *Enerhaul, Inc. v. N.L.R.B.*, 710 F.2d 748, 750 (11th Cir. 1983); and, *EuroPlast, Ltd. v. N.L.R.B.*, 33 F.3d 16, 17 (7th Cir. 1994). ("'[T]o satisfy its burden the government must demonstrate (1) a reasonable basis in truth for the facts alleged; (2) a reasonable basis in law for the theory propounded; and (3) a reasonable connection between the facts alleged and the legal theory advanced.'") *Phil Smidt & Son, Inc. v. N.L.R.B.*, 810 F.2d 638, 642 (7th Cir. 1987).

Because the government has the burden of proof on substantial justification, CMS's failure to provide any factual or legal justification for the bulk of the deficiencies alleged and remedies imposed as part of its pre-litigation position would have been conclusive in the absence of the construction of the EAJA by the Seventh Circuit. *Pettyjohn v. Chater*, 888 F. Supp. 1065, 1067 (D.C. Colo. 1995) and *Baldi Bros. Constructors v. U.S.*, 52 Fed. Cl. 78, 82 (2002). ("Defendant remains silent on the issue of its prelitigation conduct. . . . * * * Defendant cannot prove that the Government's conduct was substantially justified when it does not address its conduct at all.")

In this case, the Seventh Circuit concluded that CMS was relieved of its obligation to establish the reasonableness of the factual allegations and legal theories embodied in its pre-litigation position because requiring it to investigate prior to acting would undermine the efficiency of its enforcement procedures and "retard the correction of the deficiencies found by the state agency." (App. 6) This holding was made without citation to any appellate court case law and apparently based upon the court's view that CMS's actions were analogous to "the interim remedies available in ordinary civil litigation such as temporary restraining orders." *Id.*

This conclusion is in apparent tension with both the language and policies embodied in 5 U.S.C. §504 and with this Court's holding in *Pierce v. Underwood, supra.* To the extent it relies on CMS's mission of protecting public health or safety, it is also in apparent

conflict with an earlier decision of the circuit court for the District of Columbia in *Contractor's Sand and Gravel, Inc. v. Federal Mine Safety and Health Review Comm'n*, 199 F.3d 1335, 1339 (D.C. Cir. 2000). This Court should therefore grant certiorari in this case to resolve these conflicts and issues.

A. The Creation Of A Separate Standard Of Reasonableness For Agencies Which Regulate In The Areas Of Public Health Or Safety Should Only Be Done After A Thorough Review By This Court.

The agency's pre-litigation position is its "action or failure to act . . . upon which the adversary adjudication is based." 5 U.S.C. §504(b)(1)(E). CMS's pre-litigation position in this case consisted of the 28 alleged deficiencies it approved. It also consisted of all the remedies which is imposed, including the $12,400.00 CMP for the IJ, the daily CMP for the other cites, the NATCEP suspension, and the suspension of reimbursement for new admissions. These were the governmental actions which prompted Park Manor's appeal and which therefore "gave rise to the litigation" within the meaning of 5 U.S.C. §504(b)(1)(E) and *Marcus*, 17 F.3d at 1036.

Twenty-one of those deficiencies supporting the remedies were either rescinded in IDR or abandoned by CMS after Park Manor undertook the costs of investigation and filing an appeal. After Park Manor prevailed in all aspects of the litigation and moved for

fees under EAJA, CMS chose not to introduce any evidence to support any of these allegations during the EAJA proceedings. In its answer to the fee application, CMS contended only that it "reasonably relied upon the findings and recommendations of the State survey agency. . . ."

The state survey agency's actions, however, are subject to approval by CMS. They may also, in fact, *be* the actions of CMS. The DAB has held in other contexts that a state survey agency is the "agent" of CMS and its acts are attributable to it. *Clermont Nursing and Convalescent Ctr. v. CMS*, DAB No. CR1087, 2003 WL 22326547 (HHS), at n. 10 (09/25/03) ("[t]he State agency acted as an agent of CMS in this survey process and references to CMS may be read to include its agent") and *Community Hosp. of Long Beach v. CMS*, DAB No. 1938 (08/18/04), 2004 WL 2102876 (HHS), pp. 1-2 ("CMS and its agents (such as state survey agencies) . . . ").

The circuit court concluded that CMS was entitled to rely on the allegations in the SOD[3] and had no

---

[3] The Seventh Circuit's comment that the SOD itself establishes a prima facie case is based upon its reading of *Harmony Court v. CMS*, DAB Dec. No. 1968 (2005), Medicare and Medicaid Guide (CCH) ¶ 120803, 2005 WL 835751. *Harmony Court*, however, did not hold that the allegations in an SOD are always sufficient to establish a prima facie case. It held only that they will do so where the assertions in the SOD have not been disputed by the provider. ("' . . . CMS may make a prima facie showing of noncompliance based on that document if the factual findings and allegations it contains are specific,

(Continued on following page)

duty to investigate or test the legal viability of any of these allegations. (App. 5-6) It likened CMS's approving these deficiencies and imposing the remedies without any evaluation of the facts and law upon which they may have been based to interim remedies which are routinely available in court proceedings. (App. 6) The exact meaning intended by this analogy is not clear, since the issuance of a temporary restraining order presupposes the evaluation of the facts and law, based on defined legal standards, by a neutral magistrate.

This holding, that an agency is excused from insuring that its positions are reasonably based upon the facts and law when it determines that conducting such an analysis prior to acting might cause the agency's enforcement process to lose "economy" or "retard the correction of the [alleged] deficiencies,"[4] is in substantial tension with Congress' directive in 5 U.S.C. §§504(a)(1) and (b)(1)(E) that an agency's actions must have a reasonable basis in fact and law.

This holding by the Seventh Circuit also, by necessity, would limit any review of the government's "position" to a review of the position it takes after the litigation is underway. Such a limitation would not comport with other court decisions construing the

---

undisputed, and not inherently unreliable.'") *Harmony Court*, DAB Dec. No. 1968 at Westlaw 11. (Emphasis added.)

[4] How forcing providers to expend resources to correct deficiencies that do not exist furthers CMS's goal of protecting resident health and welfare is not explained.

requirements of EAJA. See, *Iowa Express Distribution, Inc. v. N.L.R.B.*, *supra*, at 1309. ("The litigation position approach does not address what we must conclude is at least a significant purpose of the EAJA – to encourage government regulatory agencies only to take actions that have a reasonable basis in law and in fact.")

In deciding that an agency was excused from determining substantial justification prior to acting in this type of case, the Seventh Circuit reasoned that "[i]mposing interim sanctions in advance of full investigation is a sensible procedure with familiar analogs in the interim remedies available in ordinary civil litigation, such as temporary restraining orders." (App. 6)[5] Not only has this analogy never before been used in evaluating whether the government's position was substantially justified, but if adopted by the lower courts, it has the potential to create an exception to the definition of an agency's position in §504(b)(1)(E) which would swallow the rule.

The EAJA is a federal statute designed, at least in significant part, to reduce or eliminate unreasonable government action that leads to litigation. See *Commissioner I.N.S. v. Jean*, *supra*. "The Government's general interest in protecting the federal fisc

[5] The court did not explain its characterization of the remedies sought by CMS as "interim remedies." Absent a successful appeal by Park Manor, all of the remedies, including the CMPs, would have been enforced.

is subordinate to the specific statutory goals of encouraging private parties to vindicate their rights and 'curbing excessive regulation and the unreasonable exercise of Government authority.'" 496 U.S. at 164-165. Since governmental actions that do not have a reasonable basis in fact or law are those most likely to be challenged, EAJA also serves to reduce the volume of litigation. A construction of EAJA which significantly limits its reach, and which is not based upon the language of the statute, should therefore not be adopted without a thorough analysis by this Court.

B. The Circuit Court's Holding That CMS Is Not Required To Investigate Prior To Imposing Remedies Is In Apparent Conflict With Principles Established By A Decision Of Another Circuit Court.

The circuit court determined that requiring CMS to verify the accuracy of the allegations before imposing remedies would "retard the correction of the deficiencies. . . ."[6] This method of analysis, which seeks to temper the requirements of the EAJA with the perceived mission of the agency, was previously rejected by the circuit court for the District of Columbia in *Contractor's Sand and Gravel, Inc.*, 199 F.3d 1335, 1339 (D.C. Cir. 2000).

---

[6] How imposing remedies for, and requiring nursing homes to divert resources to correct, non-existent deficiencies protects resident health or safety is not explained.

In *Contractor's Sand and Gravel, Inc.*, the agency initiated an enforcement proceeding against a mine operator for failing to properly ground equipment. Without offering any evidence that the equipment was not, in fact, grounded, the agency argued that the frame grounding employed by the company was inherently unsafe. After that position was rejected in the litigation, the agency defended the EAJA claim, not on the reasonableness of its factual and legal position, but on its need to act to protect public safety. The court rejected this argument. ("The Commission's determination that the Secretary's position had a reasonable basis in law is based entirely on an analysis which examines the purpose of the regulations in terms of the overriding objective of safety in the mine. . . .") 199 F.3d at 1340.

While CMS undoubtedly does have, as its mission, the goal of promptly remedying deficient nursing home practices, the same could be said about the numerous other federal agencies which serve to protect public health and safety. The implications of the holding by the Seventh Circuit therefore go well beyond the nursing home enforcement process.

It is at least reasonable to conclude that Congress was aware of the tension between agencies' need to sometimes act promptly, and a requirement that they verify the legal and factual reasonableness of its position prior to acting, when it adopted the EAJA. In opting for the requirement of substantial justification, Congress appears to have decided to balance these two competing policies in favor of the

goals embodied in the EAJA. This Court should therefore accept this case to resolve this conflict between the two circuit court decisions.

III. THE DAB'S CONCLUSION, THAT AN AGENCY'S POSITION IS SUBSTANTIALLY JUSTIFIED IF SOME ALLEGATIONS HAVE A REASONABLE BASIS IN FACT AND LAW BUT THE LARGER PORTION DOES NOT, CONFLICTS WITH DECISIONS OF OTHER CIRCUIT COURTS.

This Court in *Commissioner, I.N.S. v. Jean*, 496 U.S. 154 (1990), held that in determining substantial justification, the position of the government is to be viewed as an inclusive whole. 496 U.S. at 158-159. The DAB, in applying that principle, held that CMS could pursue numerous deficiencies and remedies so long as it could later demonstrate that one or more deficiencies, that could arguably support the remedies imposed, had a reasonable basis. "CMS's pre-adjudication actions can be considered reasonable for EAJA purposes if there are *some* legally sufficient grounds for the actions regardless of whether other allegations were made that might have affected how CMS exercised its discretion." (Emphasis in original.) (App. 47)

This holding was appealed to the circuit court, but, due to that court's holding that CMS was entitled to rely on the allegations in the SOD, it was not addressed. This holding by the DAB, however, is contrary to other established circuit court precedent

construing the EAJA. See *United States v. Jones*, 125 F.3d 1418, 1428-1429 (11th Cir. 1997); *Hanover Potato Prod., Inc. v. Shalala*, 989 F.2d 123, 131 (3rd Cir. 1993); and *Alphin v. Nat'l Transp. Safety Bd.*, 839 F.2d 817, 822 (D.C. Cir. 1988).

In *Alphin*, the FAA initiated a proceeding to suspend an inspector's certificate. It alleged a number of code violations and, as in the present proceedings, the private party had the burden of proof to show compliance. When the FAA's allegations were dismissed, the inspector moved for fees. The NTSB concluded that one of the charges, the failure to detect a cracked crankshaft, was substantially justified and would have supported the suspension sought and it denied fees. 839 F.2d at 821-822. In reversing that denial, the court reasoned:

> Although we agree with the Board that the cracked crankshaft alone validated the FAA's decision to proceed against Alphin, we can not condone the shotgun approach used by the FAA. Simply because the cracked crankshaft, if proved, could have supported the suspension, the FAA is not entitled to tack on other meritless allegations. Each allegation had to be disproved by Alphin. . . .

Alphin at 822.

The reasoning in *Alphin* was reaffirmed in *Air Transp. Ass'n of Can. v. Fed. Aviation Admin.*, 156 F.3d 1329 (D.C. Cir. 1998). In *Air Transp. Ass'n* all but one of the government's allegations had been

found to be substantially justified. The court nevertheless found a fee award appropriate under the EAJA:

> Virtually any government action is either grouped with other actions or is a component of some greater action. * * * If a litigant who has successfully challenged a government action as substantially unjustified and achieved a complete victory in terms of the relief prayed cannot recover EAJA fees because of this well-nigh universal grouping, then Congress' enactment of the EAJA becomes a virtual nullity.

Id. at 1332.

Since the DAB's decision has been published, it serves as a basis for deciding fee applications within HHS, and may influence the analysis of such cases in other settings. This Court should therefore grant the petition for certiorari to resolve this conflict and determine the standards which should apply when some of the government's position is substantially justified, but an equal or larger portion is not.

CONCLUSION

For all of the above reasons, petitioner respectfully requests that the Supreme Court grant this petition for certiorari to review the decision of the Seventh Circuit Court of Appeals.

Executed on October 19, 2007.

Respectfully submitted,

ROBERT M. HESSLINK, JR.
HESSLINK LAW OFFICES, S.C.
State Bar No. 1013876
Counsel of Record for Petitioner
P.O. Box 930005
Verona, WI 53593-0005
(608) 845-3775

495 F.3d 433

United States Court of Appeals, Seventh Circuit.

PARK MANOR, LTD., Petitioner,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondent.

No. 06-3521.

Argued May 4, 2007.
Decided July 23, 2007.

Robert M. Hesslink, Jr. (argued), Verona, WI, for Petitioner.

Michael O. Leavitt, Department of Health and Human Services, Washington, DC, Donna Morris Weinstein, Barbara F. Altman (argued), Department of Health and Human Services, Office of the General Counsel, Chicago, IL, Richard D. Humphrey, Office of U.S. Attorney, Madison, WI, for Respondent.

Before POSNER, MANION, and KANNE, Circuit Judges.

POSNER, Circuit Judge.

The petitioner, Park Manor, a nursing home, asks us to reverse the denial by HHS's Departmental Appeals Board of an award of attorneys' fees under two provisions of the Equal Access to Justice Act, 5 U.S.C. §§ 504(a)(1) and (4). We have jurisdiction because, had Park Manor lost before the Board and sought judicial review, we would have had jurisdiction of that review proceeding. 42 U.S.C. § 1320a-7a(e).

The first subsection of section 504(a) provides that "an agency that conducts an adversary adjudication shall award, to a prevailing party other than the United States," the party's reasonable attorney's fees unless the government's position was "substantially justified." An agency within the Department of Health and Human Services called CMS (Centers for Medicare & Medicaid Services) is responsible for making sure that nursing homes that receive reimbursement under the Medicare program comply with the various rules that HHS has issued for the protection of the residents of nursing homes. *Fairfax Nursing Home, Inc. v. HHS,* 300 F.3d 835, 836 (7th Cir.2002); *Mimiya Hospital, Inc. v. HHS,* 331 F.3d 178, 179 (1st Cir.2003). To this end CMS conducts annual "surveys" (inspections of nursing homes). Only it doesn't conduct the inspections itself; it has delegated the task to state health agencies that employ nurses, nutritionists, and other health professionals to inspect nursing homes for violations of applicable rules. *Id.* at 179. If the state agency reports to CMS that it has found violations, CMS can forthwith impose sanctions, such as civil penalties and denial to the nursing home of reimbursement for the expenses of new residents. 42 U.S.C § 1395i-3(h)(2). The nursing home can challenge the sanctions, as Park Manor did here, and the ruling of the first-level decider, an administrative law judge in HHS, is reviewable by the Departmental Appeals Board and then by the court of appeals.

Inspections of Park Manor conducted by the Wisconsin health agency in 2001 yielded a 123-page report to CMS. The agency had found 28 violations. CMS responded by imposing temporary sanctions but later suspended them because Park Manor was back in compliance. By the time the case came before the administrative law judge for a determination of the validity of the charges and the possible imposition of permanent sanctions, CMS had dropped all but seven of the charges. The administrative law judge dismissed two more on summary judgment. He then decided that if he sustained just one of the five remaining charges, this would support the sanctions that CMS was seeking and he wouldn't have to consider the other four charges. So he picked one, sustained it, and disregarded the rest. The Departmental Appeals Board reversed the ruling sustaining the one charge, but declined to remand the case for the administrative law judge to rule on the other four charges because CMS had not made an issue before the Board of the administrative law judge's declining to consider them.

That would have ended the proceeding had not Park Manor sought reimbursement under the Equal Access to Justice Act of $289,000 in attorneys' fees. The administrative law judge denied the claim in its entirety, finding that all the charges brought by CMS, including those that CMS had dropped and those he had dismissed on summary judgment, had been substantially justified. The Departmental Appeals Board affirmed except with respect to one of the two

charges that had been dismissed on summary judgment, and so awarded Park Manor a portion of the fees it sought, but a tiny portion – less than $7,000. *Park Manor Nursing Home v. Centers for Medicare & Medicaid Services,* DAB No. A-05-37, 2005 WL 3753088 (DAB Dec. 16, 2005).

The Board ruled that it did not have to review the merits of the 21 charges that CMS had dropped before the hearing conducted by the administrative law judge. It ruled that way because it rejected Park Manor's contention that "CMS may not reasonably rely on state survey findings in making its remedy decisions but must investigate – or look behind – those findings to verify their correctness before deciding to impose remedies." The Board said that "this premise is inconsistent with the enforcement process. . . . Reliance by CMS on state survey findings is precisely what this process permits and encourages. Requiring CMS to investigate every facility before imposing remedies would frustrate the goals of protecting residents and encouraging facilities to correct quickly any deficiencies that jeopardize resident health and safety." *Id.*

The Board found that all but one of the charges that CMS had ultimately pursued were substantially justified by the information contained in the detailed report of Wisconsin's health agency. That finding is supported by substantial evidence and thus binds us. But that leaves the other 21 charges, the ones CMS dropped before the hearing. If any of those charges were not substantially justified, Park Manor

is entitled to be reimbursed for the portion of its attorney's fees that is reasonably allocable to them. *EuroPlast, Ltd. v. NLRB,* 33 F.3d 16, 16-17 (7th Cir.1994); *American Wrecking Corp. v. Secretary of Labor,* 364 F.3d 321, 325-26 (D.C.Cir.2004) (per curiam). They were dropped early in the process initiated by the survey, but they gave rise to interim sanctions, and Park Manor incurred attorney's fees in getting the sanctions lifted and argues that CMS should not have imposed the interim sanctions without *independently* determining whether the report of the state agency – the source of the findings on which the sanctions were based – was accurate.

HHS must show that CMS was substantially justified in taking the steps it took that led up to the formal proceeding before the administrative law judge, as well as in the steps it took in that proceeding. 5 U.S.C. § 504(b)(1)(E); *United States v. Hallmark Construction Co.,* 200 F.3d 1076, 1080-81 (7th Cir.2000); *Roanoke River Basin Ass'n v. Hudson,* 991 F.2d 132, 138-39 (4th Cir.1993); *Natural Resources Defense Council, Inc. v. EPA,* 703 F.2d 700, 706-07 (3d Cir.1983). But CMS has delegated on-site inspection of nursing homes to responsible state agencies, and the delegation is not only lawful, 42 U.S.C. § 1395aa(a), but sensible. The states impose their own rules on nursing homes, and it is efficient to have the same agency investigate compliance with both sets of rules rather than to have two inspections of the same nursing home by two agencies. The economy achieved by delegation would be lost if

before acting on the results of the state agency's report the federal government had to duplicate the agency's investigation on pain of having to reimburse the nursing home's attorney's fees should the state report prove to contain critical errors. That would also retard the correction of the deficiencies found by the state agency, here quickly achieved when CMS imposed interim sanctions.

Park Manor argues that the state agency's reports are one-sided, nonadversary, and therefore unreliable. It might as well argue that the government cannot put a person to the expense of defending against a criminal charge on the basis of a grand jury's indictment, as proceedings before a grand jury are one-sided too; an indictment establishes probable cause to believe the defendant guilty of crime, and no more is required to justify instituting a criminal proceeding. The state agency's report of violations establishes probable cause for CMS to impose interim sanctions and seek permanent ones, and no more is required to establish substantial justification under section 504(a)(1). *Park Manor Nursing Home v. Centers for Medicare & Medicaid Services, supra*; *Harmony Court v. Centers for Medicare & Medicaid Services,* DAB No. 1968, 2005 WL 835751 (DAB Mar. 28, 2005). Imposing interim sanctions in advance of full investigation is a sensible procedure with familiar analogs in the interim remedies available in ordinary civil litigation, such as temporary restraining orders.

Park Manor has another arrow in its quiver. Section 504(a)(4) provides that if "the demand [made of a party] by the agency is substantially in excess of the decision of the adjudicative officer and is unreasonable when compared with such decision, under the facts and circumstances of the case," the party is entitled to the attorneys' fees that it reasonably incurred in resisting the demand. Park Manor argues that since HHS awarded the government no relief at all, CMS's demand for sanctions must have been "substantially in excess of the decision" and "unreasonable when compared with" the decision.

Park Manor admits that this interpretation would undercut the "substantially justified" standard of subsection (1) by giving litigants a second bite at the same apple under a different (but seemingly not a more demanding) standard. The sensible interpretation, which avoids this anomaly, confines subsection (4) to the case in which the government prevails but the relief it obtains is meager in comparison to the relief it had sought. *American Wrecking Corp. v. Secretary of Labor, supra,* 364 F.3d at 327-28; *see* Judith E. Kramer, *"Equal Access to Justice Act Amendments of 1996: A New Avenue for Recovering Fees from the Government,"* 51 Admin. L.Rev. 363, 376 (1999). By seeking excessive relief, an agency forces the party against which it is proceeding to incur an excessive expense to defend itself. The proceeding is justified, so far as the party's liability is concerned; it is only the relief demanded that is unjustifiable. The parallel is to Rule 68 of the Federal

Rules of Civil Procedure, which relieves a defendant from having to pay the plaintiff's costs if having refused the defendant's offer of judgment the plaintiff obtains a smaller judgment. The rule penalizes the greedy winning plaintiff but is inapplicable if the defendant wins. *See Delta Air Lines, Inc. v. August,* 450 U.S. 346, 101 S.Ct. 1146, 67 L.Ed.2d 287 (1981). Subsection (4) has a similar office, and thus has no application to this case because the entity against which the government was proceeding, Park Manor, prevailed.

The petition for review is

DENIED.

2005 WL 3753088 (H.H.S.)

Department of Health and Human Services (H.H.S.)

Departmental Appeals Board

Appellate Division

IN THE CASE OF: PARK MANOR NURSING HOME, PETITIONER

v.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Civil Remedies CR1263
App. Div. Docket No. A-05-37
Decision No. 2005

December 16, 2005

DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE EAJA DECISION

In March and June 2001, the State of Wisconsin conducted surveys of Park Manor Nursing Home (Park Manor) and found noncompliance with Medicare participation requirements. Based on the survey findings, the Centers for Medicare & Medicaid Services (CMS) imposed civil money penalties and other remedies on Park Manor. Park Manor requested a hearing before an Administrative Law Judge (ALJ) at the Departmental Appeals Board (Board). After the State withdrew some of the noncompliance findings, CMS chose to go forward based on six findings from the March survey and one finding from the June survey. The ALJ granted summary judgment in Park Manor's favor on two of these findings, overturning

the remedies from the June survey as a result. He conducted a hearing on the remaining five findings and issued an initial decision in CMS's favor, based on one of the findings. On review, the Board reversed the ALJ, issuing a final decision in Park Manor's favor. CMS did not timely pursue before the Board the other four findings. Thus, during the proceedings, all of the noncompliance findings were withdrawn, not pursued, or reversed, and all of the enforcement remedies were overturned.

Having obtained a favorable result on the merits, Park Manor applied for attorneys' fees and other expenses pursuant to the Equal Access to Justice Act (EAJA), 5 U.S.C. § 504. Among other things, the EAJA requires a federal agency to pay the reasonable fees and other expenses incurred by an eligible "prevailing party," unless the "position of the agency" in the underlying "adversary adjudication" was "substantially justified" or "special circumstances" make an award unjust.

On December 28, 2004, the ALJ (Steven T. Kessel) issued a decision denying Park Manor's EAJA application. *Park Manor Nursing Home*, DAB No. CR1263 (2004) (ALJ EAJA Decision). The ALJ found (among other things) that CMS was substantially justified in pursuing enforcement remedies against Park Manor. Before us now is Park Manor's appeal of the ALJ EAJA Decision.

As discussed below, the ALJ EAJA Decision does not properly apply EAJA standards, is incomplete,

and does not accurately reflect our decision on the merits. Because of the lengthy history of this case and other factors, we are issuing a modified decision, rather than remanding to the ALJ. Our major conclusions are:

- CMS had a reasonable basis for issuing the initial determinations that led to the proceedings.

- CMS also had a reasonable basis for pursuing a reduced civil money penalty for the period March 22 through June 10, 2001 (even though CMS was no longer relying on all of the findings from the March survey). Therefore, CMS's overall position regarding that matter was substantially justified.

- By obtaining summary judgment in its favor, Park Manor prevailed in its appeal of CMS's initial determination imposing remedies based on the June revisit survey – a separate matter for EAJA purposes. CMS did not show that its overall position regarding that matter was substantially justified, however. In particular, CMS did not show that it had a reasonable basis for its position that remedies for the period beginning June 11 were warranted based solely on a finding of noncompliance that the State had withdrawn during informal dispute resolution. Accordingly, Park Manor is entitled to an EAJA award for the reasonable attorneys fees and expenses it incurred in connection with the proceedings to resolve that matter (up to receipt of the summary judgment ruling), unless "special circumstances" make an award unjust.

- None of the events that CMS alleges constitute "special circumstances" relates to adjudication of the remedies arising from the June revisit survey and bars an award in connection with that matter.

- The ALJ correctly concluded that Park Manor is not entitled to an award on the basis that CMS sought excessive remedies.

Our decision below sets further procedures to enable us to promptly determine the amount to which Park Manor is entitled under our decision (if the parties cannot agree on an amount within a specified time period, as we encourage them to do). If the parties agree on the amount, our decision will become final on the matters decided herein. Otherwise, we will issue a supplementary decision which, together with this decision, will constitute final agency action on the matters.

Case Background

This case has a long and convoluted history. We set out here only the background required to understand generally how the proceedings arose, how and why the issues narrowed over the course of the proceedings, and what steps were taken at key stages of the proceedings.[1]

---

[1] The record before the ALJ in the EAJA proceeding included: (1) briefs submitted in support of or opposition to Park Manor's EAJA application, including an opening brief by Park

(Continued on following page)

A skilled nursing facility (SNF) such as Park Manor must comply with the requirements in 42 C.F.R. Part 483, subpart B, if it wishes to participate in the Medicare program. Compliance is verified through surveys performed by state survey agencies under contract with CMS. 42 C.F.R. Part 488, subpart E. A survey agency reports any "deficiency" (failure to meet a participation requirement) it finds on a standard form called a "Statement of Deficiencies" (SOD). *See, e.g.*, CMS Ex. 1. Each deficiency cited in the SOD is identified by an alpha-numeric "tag" relating to a requirement in Part 483. The survey agency also rates the seriousness of each reported deficiency by assessing scope and severity (whether it has placed residents in "immediate jeopardy," caused "actual harm," or created only the "potential for more than minimal harm"). *Id.*; *see also* 42 C.F.R. § 488.404.[2]

Manor, a CMS "Answer" to the application (CMS Answer), and a reply to the CMS Answer; (2) various exhibits in support of or opposition to the EAJA application (PM EAJA Ex. ___ and CMS EAJA Ex. ___); and (3) the record of the merits proceeding initiated by Park Manor to challenge CMS's determinations. The record of the merits proceeding includes: the parties' exhibits (PM Ex.__ and CMS Ex. ___); the hearing transcript (Tr. ___); and the pleadings, briefs, and other related pre- and post-hearing material listed (by number) in chronological sequence on a December 30, 2003 document prepared by the Civil Remedies Division (R. 1 to R. 92). Our record on appeal of the ALJ EAJA Decision also includes Park Manor's opening brief (PM Brief), a CMS response brief (CMS Response), and reply briefs filed by both parties (PM Reply and CMS Reply).

[2] Noncompliance levels are denoted by letters: D, E, and F refer to deficiencies with the potential for more than minimal

(Continued on following page)

A SNF is subject to enforcement remedies, including termination of its Medicare participation, if it is not in "substantial compliance." 42 C.F.R. § 488.402(b),(c). A SNF is not in substantial compliance if it has one or more deficiencies that create the potential for more than minimal harm. 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.*

CMS determines whether to impose an enforcement remedy on a SNF, generally after approving a state survey agency certification of noncompliance. 42 C.F.R. §§ 488.330(a); 488.330(e)(2). In lieu of termination, CMS may impose civil money penalties (CMPs) and other intermediate remedies to encourage the SNF to come back into substantial compliance promptly.[3] *See* 42 C.F.R. §§ 488.406 and 488.408. This scheme is based on section 1819 of the Social Security Act (the Act), 42 U.S.C. 1395i-3.

A SNF is entitled to an ALJ hearing to contest a federal enforcement action only if CMS issues an

---

harm"; G, H, and I refer to deficiencies that have caused "actual harm" to residents; and J, K, and L identify deficiencies that place residents in immediate jeopardy. CMS State Operations Manual (SOM), Pub. 7, App. P, sec. V.

[3] If CMS finds immediate jeopardy, CMS may impose a CMP in the range of $3,050-$10,000 per day; for other noncompliance, CMS may impose a CMP in the range of $50-$3,000 per day. 42 C.F.R. § 488.438(a)(1). A CMP accrues until the SNF has achieved substantial compliance or its provider agreement is terminated. 42 C.F.R. § 488.454(a).

appealable "initial determination." 42 C.F.R. §§ 498.3(b), 498.5, 488.330(e)(3). The definition of "initial determination" includes a finding of noncompliance that results in the imposition of a remedy specified in section 488.406, a finding of substandard quality of care that results in the loss of approval of a nurse aide training program, and the level of noncompliance found by CMS if a successful challenge on this issue would affect the range of CMP amounts that CMS may collect. 42 C.F.R. § 498.3(b)(13), (14), and (16).

A hearing on a CMP typically requires an ALJ to make findings on two issues: first, whether the SNF was, as alleged by CMS, not in substantial compliance with participation requirements during the period for which CMS imposed the CMP; and second, whether the amount of the CMP is reasonable in view of the seriousness of the noncompliance, the SNF's compliance history, and other factors. *See, e.g.*, 42 C.F.R. § 488.438.[4]

On March 22, 2001, the Wisconsin Department of Health and Family Services (WDHFS) completed a standard survey and extended survey of Park Manor (the March survey). CMS Ex. 1, at 1; CMS Ex. 3, at 1.

---

[4] Contrary to what Park Manor suggests, however, it did not have a right to review of CMS's exercise of discretion to impose remedies, rather than giving Park Manor an opportunity to correct them, nor did Park Manor's right to appeal arise before CMS issued its initial determinations. 42 C.F.R. §§ 488.438, 498.3.

As initially issued, the SOD for the March survey contained noncompliance findings under 20 tags, two of which we identify at this point. CMS Ex. 1, at 1. First, surveyors found that Park Manor had failed to consult immediately with a resident's physician about a "significant change" in the resident's status (tag F157). *Id.* at 1-9. Second, surveyors found that Park Manor had not ensured that a resident received adequate supervision to prevent accidents (tag F324). *Id.* at 86. The surveyors also found that for two days, March 20 and 21, the deficiency under tag F324 placed residents in immediate jeopardy and therefore also constituted "substandard quality of care."[5] *Id.* at 1; *see also* CMS Ex. 8, at 2.

In April 2001, before CMS made any determination based on the March survey, Park Manor filed two hearing requests. R. 1; R. 3. The first was dismissed as premature. R. 2; R. 37. The second responded to a WDHFS notice advising Park Manor that, due to the substandard quality of care finding, it would no longer be allowed to offer or conduct a nurse aide training and competency evaluation program (NATCEP).

---

[5] "Substandard quality of care" means one or more deficiencies (under 42 C.F.R. §§ 483.13, 483.15, or 483.25) that constitute either: immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm (but less than immediate jeopardy, with no actual harm). 42 C.F.R. § 488.301.

On May 4, 2001, CMS issued a "Notice of Imposition of Remedies." CMS Ex. 2. This notice informed Park Manor that CMS was imposing the following remedies based on the March survey: (1) a CMP of $6,200 per day for two days of immediate jeopardy; and (2) a CMP of $250 per day, which would accrue from March 22, 2001 until the facility achieved substantial compliance. *Id.* This notice also indicated that the alleged noncompliance with section 483.25 (tag F324) constituted "substandard quality of care," and that Park Manor was therefore prohibited from offering a NATCEP for two years. *Id.* at 1. Park Manor then filed its third hearing request. R. 12.

In early May 2001, WDHFS held an informal dispute resolution (IDR) conference regarding the March survey findings.[6] CMS Ex. 5, at 2. Park Manor submitted extensive documentation to WDHFS in support of its presentation at this conference.

On June 11, 2001, WDHFS completed a revisit survey (June revisit survey) of Park Manor and found continued noncompliance. CMS Ex. 6. The SOD for the June revisit survey cited the facility for deficiencies

---

[6] States must offer facilities an opportunity to informally dispute adverse findings in a SOD. 42 C.F.R. § 488.331(a)(1). The pendency of IDR does not toll or delay the effective date of enforcement action by CMS. 42 C.F.R. § 488.331(b)(2). However, "[i]f a provider is subsequently successful, during the [IDR] process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the [SOD] and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded." 42 C.F.R. § 488.331(c).

under six tags. *Id.* (This included a finding under tag F157 involving a different resident than the finding under that tag from the March survey.) Park Manor filed a fourth hearing request. R. 18.

On June 15 and 19, 2001, CMS and Park Manor filed Reports of Readiness in the pending appeals. R. 15-R. 17. These reports, like similar reports submitted in September, contained general assertions, but no detailed arguments. *Id.*; R. 30, R. 31, R. 33.

On June 21, 2001, WDHFS informed Park Manor that, as a result of IDR, WDHFS had amended the March survey findings under tag F324, placed the amended findings under tag F309, and reduced the noncompliance level from J (immediate jeopardy) to D (potential for more than minimal harm). CMS Ex. 7, at 1. WDHFS also agreed during IDR to withdraw or amend other March survey findings. *Id.; see also* R. 18, Att. 1. WDHFS then issued an amended SOD for the March survey, with 15 noncompliance findings (including one under tag F157). CMS Ex. 4; CMS Ex. 5, at 2.

On July 3, 2001, CMS issued a Notice of Imposition of Remedies based on the June revisit survey. CMS Ex. 7. This notice advised Park Manor that CMS was continuing the $250 per day CMP previously imposed, and imposing a denial of payment for new admissions (DPNA) starting July 15, 2001. *Id.* at 2. The notice also said that CMS had accepted WDHFS's recommendation to rescind the $6,200 per day CMP previously imposed for two days of immediate jeopardy.

Id. Park Manor then filed its fifth hearing request. R. 20 and R. 25.

On August 2, 2001, WDHFS notified Park Manor that, as a result of IDR, it was rescinding two findings from the June revisit survey – tags F157 and F281 – and amending one other finding from that survey. PM Exs. 34 and 66.

On September 20, 2001, CMS notified Park Manor by letter that it was back in substantial compliance and that all remedies had been discontinued as of July 24, 2001 (the date WDHFS conducted a second revisit survey). CMS Ex. 8. CMS also said that the IDR decision to withdraw the immediate jeopardy finding (from the March survey) had effectively overturned the substandard quality of care finding. *Id.* at 2.[7]

Meanwhile, the March survey had led WDHFS to levy fines against Park Manor for allegedly violating State nursing home requirements that are similar but not identical to the federal requirements. *See* PM Ex. 54. Park Manor contested these fines, and the resulting proceeding included a 13-day hearing before

---

[7] At this point, the following were at issue: (1) 15 noncompliance findings from the March survey, resulting in the $250 per day CMP effective March 22, 2001; and (2) six noncompliance findings from the June revisit survey, resulting in continuing the $250 per day CMP through July 23, 2001 and a DPNA for the period July 15 through July 23, 2001. The total CMP was $31,000 ($250 per day for the 124 days from March 22 to July 23, 2001).

a State ALJ. *Id.* at 2. In March 2002, while the federal ALJ proceeding was pending, the State ALJ issued a decision overturning the fines. *Id.* Shortly afterward, CMS reviewed the State ALJ decision and the evidence developed in the State proceeding. CMS Answer at 16. Based in part on that review, CMS decided not to pursue some of the related federal findings. CMS Answer at 16-17.

The federal ALJ did not issue orders setting deadlines for exchanging and submitting proposed exhibits, written testimony, and pre-hearing briefs until February and May 2002. R. 37; R. 43. CMS submitted proposed exhibits (including written direct testimony), a witness list, and a pre-hearing brief on July 15, 2002. The pre-hearing brief advised the ALJ and Park Manor that CMS had elected to go forward on only six of the March survey findings (tags F157, F279, F309, F332, F444, and F496) and on only one finding from the June revisit survey (tag F157). R. 44 (Brief at 3, n.3). Accordingly, CMS reduced the $250 CMP to $150 per day for the period March 22 through June 10, 2001, and $100 per day for the period June 11 through July 23, 2001. *Id.*

On August 9, 2002, Park Manor moved for summary judgment on all of the findings and remedies at issue in the proceedings. R. 47. Among other things, Park Manor asserted that the sole remaining noncompliance finding from the June revisit survey – the finding under tag F157 – had been rescinded during IDR and thus could not be used to support the remedies imposed for the period June 11 through July 23,

2001. *Id.* at 11-13, 39-43. While the motion was pending, Park Manor filed its exhibits, written direct testimony, and list of proposed witnesses. R. 50. Some of the testimony addressed the findings under tag F157 in the original SOD from the June revisit survey. *See, e.g.*, P. Ex. 61, at 23; P. Ex. 68, at 32.

On October 8, 2002, the ALJ ruled that Park Manor was entitled to summary judgment concerning tag F157 because CMS had not taken the steps necessary to overrule the IDR decision. R. 60, at 3-6. The ALJ also ruled that no CMP or other remedy could be imposed for the period June 11 through July 23, 2001 because CMS had abandoned its reliance on all findings from the June revisit survey except for tag F157. *Id.* at 6. As a result, there was, as of October 8, 2002, no longer an issue about remedies for the period June 11 through July 23, 2001.

The ALJ also granted summary judgment to Park Manor with respect to tag F444 from the March survey, but denied summary judgment with respect to the other five remaining tags from that survey (F157, F279, F309, F332, and F496). R. 60, at 8. The ALJ held a hearing in February 2003 to permit cross-examination regarding these five tags. The parties then filed post-hearing briefs setting out their arguments regarding each tag. R. 83, R. 86, R. 87-88. CMS argued that Park Manor was not in substantial compliance with the requirements associated with the five remaining tags, and that noncompliance with any one of these requirements was sufficient to support a $150 per day CMP.

On September 30, 2003, the ALJ issued a decision upholding the $150 per day CMP for the period March 22 through June 10, 2001. *Park Manor Nursing Home*, DAB CR1090 (2003) (ALJ Merits Decision). In that decision, the ALJ made findings on only one of the five remaining tags – tag F157. Regarding that tag, the ALJ found that Park Manor was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) because it had failed to consult with a physician immediately about a change in Resident 20's condition. The ALJ also found that the amount of the CMP was reasonable based on his findings regarding tag F157, and therefore he did not need to address issues regarding the other four tags.

Park Manor appealed the ALJ's decision to the Board. On June 17, 2004, the Board reversed the ALJ's finding of noncompliance with section 483.10(b)(11) and set aside the $150 per day CMP. *Park Manor Nursing Home*, DAB No. 1926 (2004). The Board did not remand the case to the ALJ to address the remaining noncompliance findings because CMS had not pursued those findings before the Board and because further proceedings would not serve the remedial purpose of the regulations. CMS asked the Board to reconsider its decision, and the Board denied the request.

Then, on July 14, 2004, Park Manor filed an EAJA application seeking reimbursement of about $290,000 in attorneys fees and other expenses. Park Manor requested an award under an EAJA provision that requires a federal agency to pay the reasonable

fees and other expenses of an eligible "prevailing party" in an "adversary adjudication" conducted by the agency unless the "position of the agency" in the adjudication was "substantially justified" or "special circumstances make an award unjust." Park Manor also contended that it was entitled to an award under an EAJA provision that authorizes an award when an agency makes an "excessive demand" in enforcing the party's compliance with a statutory or regulatory requirement.

The ALJ denied the EAJA application in its entirety. He found that although Park Manor was a "prevailing party" and an eligible entity under the EAJA, Park Manor was not entitled to an award because CMS was substantially justified in determining to impose remedies, specifically, in: (1) alleging that Park Manor failed to comply with the requirements of section 483.10(b)(11) (tag F157); (2) alleging four additional deficiencies (tags F279, F309, F332, and F496) that might, in themselves, have served as a basis for imposing remedies; and (3) determining to impose a $150 per day CMP. The ALJ also rejected Park Manor's request for an award on the basis that CMS had made an excessive demand, finding that this basis does not apply when the party opposing the federal agency "prevails entirely" in the underlying proceeding, as Park Manor did. *Id.* at 16-19. The ALJ noted that, in any event, the $150 per day CMP was not excessive. *Id.* at 18.

Park Manor now objects to most of the ALJ's key findings and conclusions, asserting that the ALJ

failed to apply, or misapplied, relevant legal standards and that CMS's pursuit or defense of enforcement remedies was unjustified at every stage of the merits proceeding. In response to Park Manor's appeal, CMS also takes exception to several aspects of the ALJ's decision.

Discussion

We begin our discussion by briefly addressing, in section A, the parties' dispute about the appropriate standard for our review.

Next, in section B, we address whether the ALJ correctly determined that Park Manor was not entitled to an award as a prevailing party, as follows:

- In section B.1, we set out the prerequisites for awarding a "prevailing party" fees and expenses, with particular emphasis on the legal standard that must be applied in determining whether the agency's "position" is "substantially justified."

- In section B.2, we explain why we conclude that the ALJ's substantial justification analysis is not adequate and why we consider it appropriate to issue a modified and supplemented decision, rather than remanding this case to the ALJ.

- In section B.3, we explain why we find that CMS had a reasonable basis for issuing the initial determinations that were the basis for the merits proceedings, even though CMS revised, withdrew, or chose not to rely on some of the survey findings during the proceedings.

- In section B.4, we explain why we find that CMS had a reasonable basis for continuing to pursue six findings from the March survey in the proceeding and was substantially justified in its overall position that a CMP was warranted based on noncompliance findings from the March survey.

- In section B.5, we explain why we find that CMS did not have a reasonable basis for seeking remedies based on the finding under tag F157 that WDHFS had withdrawn during IDR, that CMS's overall position seeking remedies based on the June revisit survey was not substantially justified, and that Park Manor is entitled to an award for the reasonable fees and expenses it incurred to overturn the remedies from the June revisit survey because there are no special circumstances that make such an award unjust.

In section C, we explain why we uphold the ALJ's conclusion that Park Manor is not entitled to an award on the basis that CMS made an "excessive demand."

In section D, we explain why we uphold the ALJ's ruling denying Park Manor's request to withhold certain financial records from public disclosure.

Finally, in section E, we establish a schedule for further submissions on the amount of the allowable award.

A. The Board's standard of review in EAJA cases

Park Manor argues that a substantial justification determination is a legal conclusion that the Board should review *de novo*. PM Reply at 10-12. CMS, on the other hand, asserts that the issues of whether an agency position is substantially justified, or whether "special circumstances" make an EAJA award unjust, are questions of fact whose resolution by the ALJ should be reviewed under a "substantial evidence" standard. CMS Reply at 3-8.

The Department of Health and Human Services (HHS) has issued regulations to implement the EAJA. 45 C.F.R. Part 13. These regulations were last amended in January 2004. 69 Fed. Reg. 2843 (Jan. 21, 2004). The January 2004 amendments became effective on February 20, 2004, before Park Manor filed its EAJA application, and both parties cited them as applicable here.

The regulations provide that the "adjudicative officer" who presided in the proceeding, such as an ALJ, shall issue an "initial decision" containing written "findings" on, among other things, whether the agency's position was substantially justified and whether special circumstances make the award unjust. 45 C.F.R. § 13.26. The regulations designate the Board (the HHS "component that would have jurisdiction over an appeal of the merits") as the "appellate authority" responsible for "review of the adjudicative officer's decision on the fee application[.]" 45 C.F.R. § 13.27(a), (b).

It is clear, then, that the Board is in an appellate posture with respect to the ALJ's findings about whether to make an EAJA award. Accordingly, our guidelines on review of ALJ EAJA decisions provide that the standard of review on a disputed factual issue is whether the ALJ's decision is supported by substantial evidence in the whole record, and that the standard of review on a disputed issue of law is whether the ALJ's decision is erroneous.[8]

As CMS argues, there are sound reasons for us to defer to an ALJ on EAJA issues that involve evaluating the parties' behavior during the proceedings before the ALJ (such as whether that behavior is a special circumstance making an EAJA award unjust), or on other matters with respect to which the ALJ is best situated to make a judgment.

Park Manor argues, however, that the "substantial justification" test (which we discuss below) is a purely legal standard and not a factual matter to evaluate under the substantial evidence test, as CMS argues that we should. As explained below, the "substantial justification" test requires an analysis of whether CMS's position had a reasonable basis in law and fact. Whether CMS had a reasonable basis in law is a matter that we review for legal error under our guidelines – a *de novo* review. Whether CMS had a

---

[8] *Guidelines – Review of Initial Decisions on Fee Applications Under the Equal Access to Justice Act*, http://www.hhs.gov/dab/guidelines/eaja.html.

reasonable basis in fact does not generally require either the ALJ or us to determine what the facts were; instead, the analysis focuses on whether CMS had a reasonable factual basis, given the undisputed facts and the evidence regarding disputed facts, for the position CMS took. This is not a purely factual question. Since, however, the substantial evidence standard calls for us to defer to an ALJ's inferences drawn from the evidence so long as those inferences were reasonable, even if we may not have drawn those inferences ourselves, we similarly in an EAJA case defer to an ALJ's reasonable judgment on whether there was a reasonable basis in fact for the agency position (so long as the ALJ did a correct analysis under the EAJA). Also, if the ALJ makes findings of fact regarding disputed factual issues such as what evidence an agency had available at a particular stage of the proceedings, we apply the substantial evidence standard to review those findings.

We note, however, that where, as here, a party raises threshold issues about whether an ALJ applied the correct legal standards under the EAJA in determining whether the agency position was substantially justified, those issues *are* purely legal ones that we review *de novo*. *Hanover Potato Products, Inc., v. Shalala*, 989 F.2d 123, 127 (3rd Cir. 1993). If we agree that the ALJ made a prejudicial legal error, then we must determine whether to remand the case or to resolve it ourselves, applying the correct test and addressing any material issue the ALJ did not address. If applying that test requires us to address

factual disputes on which the ALJ made findings, however, we then apply the substantial evidence standard.

B. Park Manor's request for an EAJA award under 5 U.S.C. § 504(a)(1)

1. *Requirements for an award to a "prevailing party"*

Under the EAJA, a federal agency that conducts an "adversary adjudication" must award to an eligible "prevailing party" the "fees and other expenses incurred by that party in connection with that proceeding, unless the adjudicative officer of the agency finds that the *position of the agency was substantially justified* or that special circumstances make an award unjust." 5 U.S.C. § 504(a)(1) (emphasis added).

In this case, CMS does not deny that there was an "adversary adjudication" and that Park Manor met the requirements for award eligibility. Also, although Park Manor asserts that the ALJ failed to consider all of the issues on which Park Manor prevailed, CMS does not challenge the ALJ's finding that Park Manor was a "prevailing party." Park Manor is therefore entitled to fees and expenses in connection with the proceedings unless CMS's "position" was "substantially justified" or "special circumstances" make an award unjust.

According to the EAJA statute (as amended in 1996), the "position of the agency" refers not only to the "position taken by the agency in the adversary

adjudication," but to "the action or failure to act by the agency upon which the adversary adjudication is based." 5 U.S.C. § 504(b)(1)(E). Similarly, HHS's EAJA regulations state that the agency's position "includes, in addition to the position taken by the agency in the proceeding, the agency action or failure to act that was the basis for the proceeding." 45 C.F.R. § 13.5(b)(1).

The EAJA does not define the term "substantially justified." The regulations, however, provide that an agency's position is substantially justified if it "was reasonable in law and fact." 45 C.F.R. § 13.5(b)(1). The regulations further provide that a substantial justification finding must be based on the administrative record as a whole, and that a party's status as a prevailing party does not create a presumption that the agency's position in the proceeding was not substantially justified. *Id.* However, the agency's litigating party (here CMS) has the burden of proving that its position was substantially justified. *Id.*

These regulatory criteria reflect court decisions on the EAJA. The Supreme Court has said that the government's position "can be justified even though it is not correct, and . . . it can be substantially (*i.e.*, for the most part) justified if a reasonable person could think it correct, that is, if it has a reasonable basis in law and fact." *Pierce v. Underwood*, 487 U.S. 552, 566, n.2 (1988). The courts emphasize that, in performing a substantial justification analysis, a tribunal applies a different standard than the standard used to adjudicate the prevailing party's rights in the underlying

merits proceeding. *United States v. Hallmark Const. Co.*, 200 F.3d 1076, 1080 (7th Cir. 2000). Consequently, the findings or conclusions that support the decision on the prevailing party's merits claim, and other circumstances relevant to that decision (such as the stage of the proceeding when it was made), are rarely conclusive factors in a substantial justification analysis.[9] *Id.* at 1079-80; *F.J. Vollmer Co. v. Magaw*, 102 F.2d 591, 595-96 (D.C. Cir. 1996). According to one court, a proper substantial justification analysis focuses on "'the actual merits of the Government's litigating position'" and is global or comprehensive in scope, examining "not simply whether the government was substantially justified at the beginning or end of the proceedings, but whether the government was substantially justified in continuing to push forward at each stage." *Hallmark*, 200 F.3d at 1080 (quoting *Pierce*, 487 U.S. at 569).

Because a substantial justification inquiry focuses on the agency's litigation position in the merits proceeding, the context in which that proceeding arose and was conducted may be relevant in evaluating the agency's position. We found no court opinion applying the EAJA to a case arising from the nursing facility enforcement process. Based on our experience

---

[9] "Conceivably, the Government could take a position that is not substantially justified, yet win; even more likely, it could take a position that is substantially justified, yet lose." *Pierce*, 487 U.S. at 569.

with this process, we consider the following factors to be important to an EAJA analysis in this context:

- The enforcement process is based on the assumption that all participation requirements must be met. Thus, the enforcement regulations in 42 C.F.R. Part 488 authorize CMS to impose a CMP or other remedy based on any finding of noncompliance. 42 C.F.R. § 488.408(d)(3)(i). The goal of the requirements is to protect the health and safety of vulnerable facility residents. For this reason, the facility has the ultimate burden of persuasion in an enforcement proceeding to show substantial compliance once CMS has made a *prima facie* case of noncompliance. *Batavia Nursing and Convalescent Center*, DAB No. 1911 (2004).

- The enforcement process contemplates that CMS will usually rely on state surveys to determine whether a facility is in substantial compliance and whether to impose remedies to compel corrective action. CMS may approve or disapprove a state survey agency's certification of noncompliance. 42 C.F.R. § 488.330(a)(1)(C). If CMS approves, CMS then "imposes remedies promptly" after "promptly notifying the facility of the deficiencies and impending remedy or remedies[.]" 42 C.F.R. § 488.331(e)(2)(i). This process is intended, by design and statutory mandate, to "minimize the time between the identification of violations and final imposition of the remedies[.]" Section 1819(h)(2)(B) of the Act; *see also* 59 Fed. Reg. 56,116, 56,156 (Nov. 11, 1994). The process also contemplates corrective action and revisit surveys to determine whether substantial

compliance has been achieved. 42 C.F.R. § 488.330(g)(4).

• The participation requirements seek to ensure positive resident care outcomes and to give facilities flexibility in how to achieve those outcomes. *See, e.g.*, 54 Fed. Reg. 5316, 5332 (1989). A facility is given an opportunity during a survey, through state IDR, and at the ALJ hearing to produce evidence to show that an adverse resident outcome was unavoidable.

• The hearing procedures at 42 C.F.R. Part 498 reflect the expectation that issues may be added or eliminated as the proceedings progress, new survey results are issued, survey findings are resolved through IDR or settlement discussions, and remedies are added or rescinded.

• Some of the participation requirements contain modifiers such as "significant" or "adequate" that require judgment to apply. Even experts may disagree on whether these modifiers apply to a given set of facts.

• Evaluating compliance often involves interpreting medical records, made by caregivers whose writing may be partially illegible and who often use abbreviations and symbols, including notations the relevance of which may not be readily apparent until a case is fully presented and the legal requirements have been parsed in context.

• Evaluating compliance may also involve balancing the goal of one provision (such as protecting residents' rights) with the goal of another provision (such as ensuring quality of care).

- The regulations contain a general requirement for services consistent with professional standards of quality. 42 C.F.R. § 483.20(k)(3). Those standards, although not explicit on the face of the regulations, often inform CMS's judgment about whether a facility is in compliance, but may be disputed or raise notice questions.

- Evidence in these cases often is not direct evidence but evidence from which a party seeks to have the adjudicator draw inferences of material facts.

These factors inform our analysis below.

2. *The ALJ's substantial justification analysis did not comply with applicable requirements.*

The ALJ denied an award to Park Manor as a prevailing party because he concluded that CMS's position was substantially justified. Park Manor contends that this conclusion is invalid because the ALJ failed to evaluate CMS's position in its totality. In particular, Park Manor contends that the ALJ failed to consider the agency actions that were the bases for the merits proceeding (actions that Park Manor claims were unreasonable) and erroneously confined his discussion to the issues addressed at the in-person hearing. Park Manor also contends that the ALJ inadequately analyzed whether CMS had reasonable bases for seeking affirmance of four findings of noncompliance (under tags F279, F309, F332, and F496) from the March survey that were not addressed in the ALJ Merits Decision. According to Park Manor,

the ALJ EAJA Decision "merely recites the allegations in the SOD" regarding these four findings and provides "[n]o analysis of the supporting and contrary evidence" and little or no "explanation of the ALJ's reasoning[.]" PM Brief at 20. Park Manor also contends that the ALJ erred in failing to consider whether CMS was justified in seeking remedies based on tag F157 from the June revisit survey, and in failing to determine whether CMS had a reasonable basis for pursuing tag F444 from the March survey. (CMS also takes exception to the ALJ's failure to address tag F444.)

We find that the ALJ did not do a substantial justification analysis that comports with the statute and regulations. As noted, the EAJA and HHS's January 2004 regulations define the phrase "position of the agency" to include the agency actions (or failures to act) that were the bases for the proceeding. The ALJ did not consider or evaluate these predicate agency actions. The ALJ EAJA Decision quotes a superseded provision that describes the substantial justification inquiry as an evaluation of whether the agency's "position in the proceeding was substantially justified at the time the proceeding was initiated." ALJ EAJA Decision at 6-7, quoting unamended 42 C.F.R. § 13.5(a). Yet, the ALJ's discussion of CMS's position in fact focused entirely on the issues addressed at the in-person hearing.

In addition, the ALJ did not adequately support his findings that CMS's position on tags F279, F309, F332, and F469 had a reasonable basis in law and

fact. Regarding each of these tags, the ALJ EAJA Decision contains a single, short paragraph that briefly states the basis for CMS's allegation of noncompliance. ALJ Merits Decision at 14-16. Although the ALJ indicated in each paragraph that his finding was based on evidence in the record, the ALJ did not describe or evaluate that evidence in any detail. Given the difficulty of applying the EAJA reasonableness standard, the significant amount of evidence introduced by the parties, and the fact that there was no previous ruling on the merits of these four tags, the ALJ should have thoroughly explained the reasons for his finding on each tag. *Hallmark Const. Co.*, 200 F.3d at 1080 (decision should contain an "evaluation of the factual and legal support for the government's position").

Another problem is that the ALJ focused only on the evidence tending to support CMS's position, indicating in each instance that this evidence was sufficient to prove Park Manor's noncompliance. Such a cursory, one-sided evaluation does not satisfy EAJA requirements and gives no assurance that the ALJ in fact considered the opposing evidence. The statute and regulations require an adjudicative officer to evaluate the agency position in light of the *entire* administrative record, including rebuttal evidence known to the agency. 45 C.F.R. § 13.5(b)(1); *Alphin v. National Transp. Safety Board*, 839 F.2d 817, 822 (D.C. Cir. 1988).

Most significantly, the ALJ did not determine whether CMS was substantially justified in pursuing

remedies based on findings from the June revisit survey. The ALJ acknowledged that his summary judgment ruling had "affected the remedies that remained at issue." ALJ EAJA Decision at 19. He did not recognize, however, that Park Manor's successful effort to overturn the remedies based on findings from the June revisit survey was a potential basis for award.

HHS's EAJA regulations provide:

> When *two or more matters are joined together for one hearing, each of which could have been heard separately* . . . and an applicant has prevailed with respect to one or several of the matters, an eligible applicant may receive an award for expenses associated only with the matters on which it prevailed if the Department's position on those matters was not substantially justified.

45 C.F.R. § 13.5(b)(2) (italics and emphasis added). In this context, a "matter," for purposes of section 13.5(b)(2), could be a request for hearing on a CMS "initial determination." While arguably CMS made four "initial determinations" (set out below), the parties litigated only two "matters" on which Park Manor was a "prevailing party." The first matter was the appeal from the finding of noncompliance resulting in the CMP for the period March 22 to June 10, 2001. This matter stemmed from CMS's May 4, 2001 determination, which Park Manor appealed on May 5, 2001. R. 12. Resolving that matter required the

ALJ to assess the merits of findings from the March survey.

The second matter was the appeal from the noncompliance finding resulting in a CMP and DPNA for the period June 11 to July 23, 2001. This matter stemmed from CMS's July 3, 2001 determination, which Park Manor appealed on July 12, 2001. R. 20. Resolving that matter required the ALJ to assess the merits of findings from the June revisit survey.

It is apparent, then, that these two matters – having arisen from separate appeals of noncompliance findings based on different surveys and resulting in different remedies – "could have been heard separately" by the ALJ. Consequently, the fact that Park Manor succeeded in overturning the remedies for the period June 11 to July 23, 2001 was a potential ground for an EAJA award.[10]

CMS's position on that matter was, of course, that the remedies were proper. As of July 2002, this position was based entirely on the June revisit survey's finding under tag F157. Park Manor opposed this position in its motion for summary judgment, contending that because the IDR decision had rescinded tag

---

[10] Indeed, had Park Manor appealed *only* the July 3, 2001 initial determination and obtained a summary judgment ruling disposing of the matter in Park Manor's favor (or had the appeals not been consolidated), Park Manor could have sought an EAJA award as prevailing party, regardless what happened with respect to CMS's May 4, 2001 determination.

F157, CMS could not rely on that tag to support the remedies. The ALJ concluded that CMS had not followed proper procedures to overrule the IDR result on tag F157, and therefore set aside the remedies that CMS had imposed based on the June revisit survey. Having obtained this favorable ruling by the ALJ, Park Manor was the prevailing party on this matter.[11]

In the EAJA proceeding before the ALJ, Park Manor argued that CMS was not justified in seeking remedies based on tag F157. The ALJ should have addressed that argument and determined whether Park Manor was entitled to an award for the reasonable fees and expenses it incurred to overturn those remedies.

Citing *Commissioner, INS v. Jean*, 496 U.S. 154 (1990) and other cases, CMS asserts that an award should not be based on a piecemeal examination of the litigation, and that we must make a single substantial justification finding encompassing the entire merits proceeding. CMS Response at 21, 27. In *Jean*,

---

[11] The Supreme Court has said that a party is a prevailing party if it "'succeed[s] on any significant issue in [the] litigation which achieves some of the benefit [it] sought in bringing suit.'" *Hensley v. Eckerhart*, 461 U.S. 424, 433 (1983) (quoting *Nadeau v. Helgemoe*, 581 F.2d 275, 278-79 (1st Cir. 1978)). In another formulation, the Court has said that a party prevails when the litigation has resulted in a "material alteration of the legal relationship of the parties in a manner which Congress sought to promote in the fee statute." *Texas State Teachers Ass'n v. Garland Indep. Sch. Dist.*, 489 U.S. 782, 792-93 (1989).

the Supreme Court stated that "[w]hile the parties' postures on individual matters may be more or less justified, the EAJA – like other fee-shifting statutes – favors treating a case as an inclusive whole, rather than as atomized line items." 496 U.S. at 161-62. The relevance of that statement to this situation is unclear because the issue in *Jean* was fairly narrow – namely, whether an EAJA award could include fees and expenses incurred by the prevailing party in the fee litigation. *Jean* did not indicate the scope of a substantial justification inquiry with respect to a proceeding in which the prevailing party sought relief from multiple government actions, any one of which was sufficient to support remedies that the party sought to avoid by participating in the proceeding. Some courts that have confronted these or similar circumstances have required the government to justify each such action and, when appropriate, have approved a partial award relating to the unjustified actions. *See, e.g., Alphin*, 839 F.2d at 822-823; *American Wrecking Corp. v. Secretary of Labor*, 362 F.3d 321, 325-26 (D.C. Cir. 2004). This approach, which HHS adopted in section 13.5(b)(2), is consistent not only with how courts define the term "prevailing party" in fee-shifting cases, but also with the purpose of the EAJA, which is "to eliminate for the average person the financial disincentive to challenge unreasonable government actions." *Jean*, 496 U.S. at 164.

We do not imply here that a substantial justification analysis must address the reasonableness of every single argument an agency makes during a

proceeding. *Roanoke River Basin Ass'n v. Hudson*, 991 F.2d 132, 138-139 (4th Cir.), *cert. denied*, 510 U.S. 864 (1993); *Hanover Potato Products*, 989 F.2d at 131 (noting that not every argument made by an agency must be substantially justified, but that a district court must evaluate every "significant argument" in order to determine whether the government's position "as a whole" was substantially justified). The analysis must, however, be consistent with the EAJA statute and regulations and must provide more than a cursory or one-sided review of the evidence.

Our finding that the ALJ did not perform a legally adequate substantial justification analysis means that we must either remand the case to the ALJ or modify the analysis. Given the history of this case, we determined that remand would take additional time and money, without contributing substantially to the result, and therefore be inconsistent with EAJA goals. Thus, we instead modify or supplement the ALJ's analysis as necessary to apply the appropriate standards. We also modify the decision to include analyses of issues raised before the ALJ that he did not address. Finally, we find it necessary to modify the ALJ's analysis regarding tag F157 from the March survey to correctly reflect our decision on the merits regarding that tag.

3. *CMS acted reasonably in taking the actions that were the bases for the proceeding.*

Having found that the ALJ did not consider the "agency actions" that were the bases for the proceeding

in evaluating the "position of the agency," we consider those actions here.

CMS contends that it reasonably relied on the survey findings in the SODs in taking these actions, and that the reasonableness of its reliance can be discerned from the face of those findings. We find merit in this contention.

Park Manor's right to a hearing arose when it timely appealed the following four "initial determinations" by CMS:

- The determination that Park Manor was not in substantial compliance as of March 22, 2001 (the date the March survey was completed), which resulted in the imposition of a $250 per day CMP effective on that date;

- The determination that Park Manor continued to be in a state of noncompliance on June 11, 2001 (the date of the first revisit survey), which resulted in a continuation of the previously imposed $250 per day CMP and a DPNA effective on July 15, 2001;

- The determination that on March 20 and 21, 2001, Park Manor had a deficiency, described under tag F324 in the initial SOD for the March survey, that placed one or more residents in "immediate jeopardy," which resulted in the imposition of a $6,200 per day CMP for those two days; and

- The determination, based on the immediate jeopardy finding under tag F324, that Park Manor had provided a "substandard quality of

care," which resulted (temporarily at least) in loss of approval of its NATCEP.

As discussed below, Park Manor was not a prevailing party in its appeal of the latter two determinations and for that and other reasons is not entitled to an award based on them. Thus, we examine CMS's pre-adjudication actions only with respect to the first two determinations.

Given the goal and structure of the enforcement process we outlined above, CMS's pre-adjudication actions are properly judged reasonable as long as (1) the SOD issued by the state survey agency contains factual allegations that provide a reasonable basis for a finding of noncompliance under the relevant requirements, (2) there are one or more findings of noncompliance that are legally sufficient to support the remedy imposed, and (3) CMS does not know or have reason to know of credible evidence that would undermine the legality of its remedy determination. Applying these criteria, we find that each of CMS's pre-adjudication actions was justified:

- *The determination resulting in the imposition of a $250 CMP as of March 22, 2001.* This determination was based initially on the March survey. In the merits proceeding, CMS presented evidence supporting six findings from that survey and reduced the per day amount to $150. As we discuss in the next section, CMS had a reasonable basis for defending those findings in the merits proceeding, and any one of them was legally sufficient to support the $150 CMP. Together, they

were also sufficient to support a $250 CMP. *See* 42 C.F.R. § 488.408(d)(3) (authorizing CMS to impose a CMP of $50-$3,000 per day for any deficiency that causes the facility not to be in substantial compliance). In short, CMS acted reasonably in issuing the determination that resulted in the imposition of a CMP as of March 22, 2001.

• *The determination resulting in continuation of the $250 per day CMP as of June 11, 2001 and the imposition of a DPNA effective July 15, 2001.* This determination was based on the June revisit survey's findings of noncompliance under six tags. The survey findings under at least four of those tags – tags F250, F281, F329, and F501 – gave CMS reasonable grounds to determine that Park Manor continued to be in a state of noncompliance as of June 11, 2001.[12] *See* CMS Ex. 6. These findings in turn authorized CMS to continue the $250 per day CMP and to impose a DPNA as well. 42 C.F.R. §§ 488.417(a)(1) and 488.408(d)(3)(i) (authorizing CMS to impose a

[12] For example, the SOD found noncompliance with 42 C.F.R. § 483.15(g) (tag F250). This section requires a facility to provide "medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." The survey agency found that Park Manor had failed to provide Resident 12 with services to help him in the dying process. Among other things, the survey agency found that Park Manor had not followed up on a physician-recommended hospice referral. The surveyors determined that this deficiency had the potential for more than minimal harm. CMS Ex. 6, at 3-4.

DPNA for days on which a facility is not in substantial compliance). Consequently, CMS acted reasonably in issuing this determination.

Park Manor points out that after it appealed, the State survey agency modified or withdrew a number of the deficiency findings during IDR; that CMS rescinded the immediate jeopardy finding and associated CMP; and that CMS elected not to rely on other findings. Park Manor contends that this abandonment, rescission, or modification of findings and remedies shows that the actions leading to the proceeding were not reasonable on the whole. Park Manor further contends that in order to avoid liability for an EAJA award, CMS was obliged to establish, with evidence and argument, that each and every citation and remedy emanating from the two surveys, not just the ones it pursued before the ALJ, had a reasonable basis. In addition, Park Manor suggests that independent investigation by CMS would have revealed the weakness of the abandoned or modified deficiency citations, and that CMS was unreasonable in not performing one before deciding to impose the remedies it did. In short, Park Manor contends that CMS's failure to justify its approval of these other survey findings warrants an EAJA award *regardless* of whether CMS had a reasonable basis for the findings it defended in the merits proceeding.

We reject this argument because we do not accept its two key premises. The first premise is that CMS may not reasonably rely on state survey findings in making its remedy decisions but must investigate – or

look behind – those findings to verify their correctness before deciding to impose remedies. However, this premise is inconsistent with the enforcement process described above. Reliance by CMS on state survey findings is precisely what this process permits and encourages. Requiring CMS to investigate every facility before imposing remedies would frustrate the goals of protecting residents and encouraging facilities to correct quickly any deficiencies that jeopardize resident health and safety. (As our criteria indicate, however, we reject CMS's suggestion that it could *never* have a duty to look behind survey findings before acting. Accepting that suggestion would undercut the EAJA goals.)

Park Manor's second premise is that CMS's remedy decisions constitute acceptance or approval of each of the many survey findings in the relevant SODs. This premise is a mistaken one because CMS may impose a CMP or other remedy based on any single finding of noncompliance. Regarding the remedies that CMS imposed for alleged deficiencies that were not at the immediate jeopardy level, Park Manor would have us conclude that those remedies were inappropriate or unreasonable *even if* CMS showed that some deficiency findings had a reasonable basis in law and fact and were otherwise legally sufficient to warrant the remedies. Park Manor points out that CMS might have chosen a different remedy (or permitted corrective action first) but for the survey findings that were later abandoned. Such speculation is irrelevant for EAJA purposes, however.

CMS's pre-adjudication actions can be considered reasonable for EAJA purposes if there are *some* legally sufficient grounds for the actions, regardless of whether other allegations were made that might have affected how CMS exercised its discretion. As discussed, there were legally sufficient grounds for CMS's pre-adjudication actions regarding the two matters on which Park Manor was a prevailing party.[13]

We do not wish to imply that the immediate jeopardy and substandard quality of care determinations were *entirely* irrelevant to the EAJA analysis. These determinations arguably constitute two additional "matters" under section 13.5(b)(2). These matters were pending before the ALJ as of May 5, 2001. They ended on July 3, 2001 when CMS withdrew the $6,200 per day CMP and the substandard quality of care finding. Because the matters were concluded in Park Manor's favor, an issue exists about whether an award can be made regarding them.

To resolve that issue, we need go no further than to inquire whether Park Manor was a prevailing party on the matters. A party is a prevailing party for purposes of the EAJA if the proceeding was a "catalytic,

---

[13] Moreover, the survey findings that were withdrawn at an early stage of the proceedings are inconsequential for purposes of a substantial justification analysis, which ultimately must evaluate the agency's overall position, considering the administrative record as a whole.

necessary, or substantial factor" in obtaining the favorable result. *Maduka v. Meissner*, 114 F.3d 1240, 1241 (D.C. Cir. 1997). Park Manor did, of course, obtain CMS's rescission of the immediate jeopardy finding, the $6,200 per day CMP, and the substandard quality of care finding. However, CMS took that action in direct response to the IDR results. No ruling by the ALJ prompted CMS to take these actions, and Park Manor was not required to submit evidence relevant to these matters in the merits proceeding. There is, in short, no basis to conclude that the proceeding before the ALJ was a catalytic, necessary, or substantial factor in resolving these matters. Consequently, Park Manor is not a prevailing party regarding these matters, and CMS was not required to show that its positions on them were substantially justified.

Even if we considered Park Manor a prevailing party on these matters, however, we would find that CMS showed it had a reasonable basis for determining that Park Manor was in a state of noncompliance at the immediate jeopardy level on March 20-21, 2001, and therefore that Park Manor had provided substandard quality of care. The survey findings were legally sufficient on their face as a basis for these actions.[14] There is no evidence that when CMS took

[14] The SOD found noncompliance with section 483.25(h)(2), which requires a facility to ensure that a resident receives "adequate supervision and assistance devices to prevent accidents." CMS Ex. 1, at 86. The SOD describes a resident whose

(Continued on following page)

the actions, CMS possessed credible evidence calling these survey findings into question.

For the reasons above, CMS had a reasonable basis for taking the actions that were the bases for the adversary adjudication.

4. *CMS's position that Park Manor was properly subject to a CMP effective on March 22, 2001 was substantially justified.*

As discussed, whether Park Manor was properly subject to a CMP effective on March 22, 2001 is one of two matters actually litigated in the merits proceedings.

---

difficulty swallowing had been documented, who had recently been hospitalized for aspiration pneumonia, and whose care plan called for extensive one-person assistance with meals. Surveyors found that Park Manor had failed to supervise and assist this resident to ensure safe intake of nourishment to prevent coughing, choking, and potential aspiration. *Id.* The SOD describes an incident on March 14 on which the resident was observed to be coughing while having breakfast but received no assistance with eating. *Id.* at 88. The SOD also describes other occasions – on March 19 or 20, 2001 – in which the resident was observed choking on liquids or showing signs of aspiration ("tracheal gurgling") in circumstances in which the assistance provided could reasonably be considered inadequate. *Id.* at 88-91. Based on the SOD, CMS could reasonably find that Park Manor failed to provide adequate supervision to guard against accidental harm from choking or aspiration and that there was "immediate jeopardy." *See* 42 C.F.R. § 488.301. The survey finding of immediate jeopardy was, in turn, sufficient to support the $6,200 per day CMP, as well as the substandard quality of care finding. 42 C.F.R. § 488.408(e); 42 C.F.R. § 488.301.

For the following reasons, we find that CMS's position on this matter was substantially justified.

First, we have just discussed why the actions that were the basis for the proceeding on this matter were reasonable. Second, for reasons set out in sections 4a.-4e. below, we conclude that CMS had reasonable bases for contending that, as of March 22, 2001, Park Manor was not in substantial compliance with the Medicare participation requirements associated with tags F157, F279, F309, F332, and F496. CMS also had reasonable grounds for defending the survey agency's finding of noncompliance under tag F444, which the ALJ overturned in his summary judgment ruling (*see* section 4f., below).

Third, Park Manor did not show in the proceeding that it had corrected these six alleged instances of noncompliance prior to the June revisit survey. Once identified, any noncompliance is presumed to continue until the state survey agency verifies correction during a revisit survey or by other acceptable means. *Spring Meadows Health Care Center*, DAB No. 1966 (2004).

Finally, the regulations authorized CMS to impose the remedy it ultimately sought – namely, a $150 per day CMP – for the alleged noncompliance. 42 C.F.R. §§ 488.434, 488.438(a)(1)(ii). Park Manor did not contend in the proceedings that the amount of this CMP was unreasonable, *see* R. 83, and a finding in favor of CMS on any one of the six contested findings was legally sufficient to support the CMP.

Park Manor argues that CMS's position on this matter was not substantially justified because CMS abandoned its reliance on multiple deficiencies that supported its determination to impose the CMP. It is true, of course, that CMS scaled back its case-in-chief during the proceeding. On July 2002, before the parties had exchanged evidence and witness lists, CMS reduced the CMP and informed the ALJ and Park Manor that it would seek $150 per day based on only six of the 17 findings from the March survey.

CMS argues that its decision to pursue only some of the findings before the ALJ did not render its overall position unreasonable because a $150-$250 per day CMP did not warrant litigation over every single finding of noncompliance. CMS Response at 27-28.

We agree with CMS. In the merits proceedings, CMS could have reasonably relied on any number of the deficiencies alleged in the SOD, provided that they were supportable and justified the amount of the CMP imposed. The six findings that CMS ultimately chose to pursue were, in fact, sufficient to support the CMP, either as modified or as originally imposed ($250 per day being only 8.3 percent of the maximum amount authorized).

CMS's decision to streamline its case would have given us more concern had CMS actually presented a case on the abandoned findings before July 2002, forcing Park Manor to mount opposition. But that it is not what happened. After September 2001, the

federal proceedings were held in abeyance while the State fines were being litigated. When the State proceedings ended, CMS reviewed the evidence developed in the State proceeding and, based on its review, decided to narrow its case-in-chief before Park Manor was required to submit its exhibits, written direct testimony, and initial pre-hearing brief. *See* CMS Answer at 16. Given these circumstances, we find that CMS took adequate and timely measures to assess the merits of its position on this matter and to narrow the scope of its case-in-chief accordingly.

We next discuss why we find that CMS had reasonable bases for defending the six contested findings from the March survey, beginning with tag F157. Although our discussion about these findings refers to undisputed facts reflected in the documentary record, we are not making findings on disputed issues of fact or reaching conclusions of law on disputed issues of law. In other words, we are not deciding whether CMS's position was the correct one, but only whether a reasonable mind could think it correct.

a. Tag F157

The ALJ's substantial justification determination was based largely on an analysis of CMS's position regarding tag F157, a position that we rejected in our previous decision. Since the ALJ's analysis does not correctly reflect the bases for our decision regarding that tag and contains other errors, we provide our

own analysis of whether CMS's position on this tag had a reasonable basis and conclude that it did.

Under tag 157 in the March survey, the SOD found:

> Between 03/02/01 and 03/06/01, resident #20 had continued problems with an elevated temperature, decrease in oxygen saturation levels to 89%, fluctuations in his pulse, increased lethargy, decline in ambulation and transfer abilities, mottling to his lower extremities, and congestion with rales in his lung fields. Between 5:26 p.m. on 03/02/01, and 9:33 a.m. on 03/05/01, there were no attempts to contact the physician. The resident's niece/guardian of person was not updated of [his] worsening condition until 12:36 p.m. on 03/05/01. By 1:46 a.m. on 03/06/01, [he] had died at the nursing home.

CMS Ex. 4, at 2.

During proceedings before the ALJ, CMS dropped the allegation concerning notice to the niece, presumably based on evidence presented by the facility that the niece had been contacted several times on the evening of Friday, March 2, and had visited the resident on Sunday, March 4. Relying on the opinion of a CMS surveyor who oversaw the state survey, CMS continued to assert that the resident showed signs and symptoms on March 3 and 4 that required immediate physician notification, beyond the notification given at 5:26 p.m. on March 2, in response to which the physician had ordered an antibiotic and

urinalysis for symptoms of a urinary tract infection (UTI). CMS Ex. 54, at ¶¶ 13-15. The surveyor's opinion, submitted as written direct testimony pursuant to the pre-hearing procedures set by the ALJ, stated that it was based on certain CMS exhibits. Those exhibits included the nurses notes for the weekend in question and a resident assessment from January, but did not include nurses notes for January and February (submitted by Park Manor) and do not indicate any awareness that the contemporaneous nurses notes evidence a conversation a Park Manor nurse had with the resident's physician at 9:46 p.m. on Friday, March 2, *after* the contact referred to in the SOD. The ALJ Merits Decision found that one of the symptoms on which the surveyor relied (oxygen saturation level) was not a significant change, but found in CMS's favor on the basis that the resident's lack of ability to ambulate, non-responsiveness (lethargy), and mottling were significant changes. His decision did not mention the 9:46 p.m. contact with the physician.

Park Manor appealed, and the Board reversed, based on the wording of the regulation and its context and history. Section 483.10(b)(11) gives a right to a resident to have a facility notify a physician of a "significant change in the resident's status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)." The regulatory history acknowledges that nursing judgment may be involved in evaluating what is significant for a particular resident, gives

examples of "life-threatening conditions" (heart attack and stroke), and supports a conclusion that the potential need for physician intervention is a factor in whether notice is required. The CMS surveyor had in effect applied the regulation to mean that each individual *sign or symptom* required physician notification if it "could affect the physical or mental well-being" of the resident, even if that sign or symptom was consistent with what had already been reported to the physician regarding a deterioration in the resident's *status*, and did not indicate a potential need for additional physician intervention consistent with exercise of the resident's right to refuse treatment.[15] The Board concluded that it was not clear that CMS, or the ALJ, had applied a standard consistent with the wording of the regulation and its history.[16]

---

[15] Contrary to what the ALJ suggests, the regulation specifically authorizes a legal guardian to exercise a resident's rights, as our decision pointed out. Also, although the ALJ questions how the requirement to notify a physician relates to the possible need for physician intervention, CMS's witness acknowledged that the purpose of notifying the physician is to obtain or alter treatment, that "no code" and "comfort measures only" mean that a resident is to be kept comfortable and pain-free at the end of life and that aggressive steps are not to be taken to extend the resident's life, and that there was no evidence in the resident's record that he was not comfortable and pain-free. Tr. at 72-76. She indicated, however, that she was unaware that the resident's plan was for "comfort measures only" and she questioned whether the resident was in fact dying. *Id.*

[16] For example, the ALJ stated that deterioration in life-threatening conditions and clinical complications were "examples"

(Continued on following page)

Applying the correct legal standard, the Board then found that at the time Park Manor had last reported to the physician on the resident's status (at 9:46 p.m. on Friday) its staff was already aware of some of the signs and symptoms that CMS later treated as evidencing changes and had viewed those signs and symptoms as indicating not merely a UTI, but as consistent with an overall continuing decline that had begun several months earlier, of a type to be expected given his age and his pre-existing diagnoses. The Board's determination was limited to the facts of the case, which included corroboration of the facility's nursing judgment regarding the resident's status by the resident's niece, who had authority to exercise the right to physician notification of a significant change in status, had personal knowledge of the status, and had nursing expertise. The Board concluded that Park Manor had reasonably thought it was complying with the requirement, under the particular circumstances of the case. DAB No. 1926, at 10-11.

While Park Manor acknowledged that mottling on the resident's extremities that appeared on Sunday, March 4 (at some time between 4:00 and 10:00 p.m.) would have been a significant change *for a "full code" resident*, Park Manor relied on nursing standards for its assertion that the mottling did not

---

of significant changes. ALJ Merits Decision at 4. But the regulation uses "i.e.," not e.g. Even CMS did not in the merits proceeding articulate the interpretation the ALJ now attributes to CMS, nor did CMS's witness.

require notification for this resident, who was "no code" and "comfort measures only." Thus, the Board did not take this acknowledgment to mean that Park Manor had conceded the mottling was a significant change requiring notice to the resident's physician beyond what Park Manor had already given. The Board concluded, however, that, even if the mottling were considered a significant change in physical status for this resident (despite the "no code" and "comfort measures only" directives), CMS had not made a *prima facie* case that the failure to notify the physician immediately of the mottling had the potential for more than minimal harm. Thus, the Board's decision was fully consistent with past Board decisions that, when there *is* a change that a facility reasonably should have known was a significant change in status, a deficiency may be found if there is no *immediate* physician notification.

The issue for EAJA purposes, however, is not whether CMS could anticipate that the Board would reach a different result, but whether CMS's position had a reasonable basis in law and fact. Although we agree with Park Manor that the ALJ misread our decision, we conclude that CMS's position on this tag did have a reasonable basis in law. First, the regulation requires a fact-based determination of whether there has been a change in a resident's physical, mental, or psychosocial status since the last physician notification and whether that change is significant for that resident. The parenthetical explanation that this means "a deterioration in status in either a

life-threatening condition or clinical complication" and the examples of heart attack or stroke as life-threatening conditions provide some guidance in evaluating what is a significant change, but are not unambiguous, particularly when applied to a fact situation as complicated as the one at issue here.[17]

Second, while the Board's decision was not, as the ALJ found, based on a "novel interpretation" inconsistent with the plain language of the regulation (ALJ EAJA Decision at 12), there were no Board decisions previously addressing the need for physician notification in equivalent circumstances. Nor had the Board previously analyzed the wording and

---

[17] Indeed, the ALJ EAJA Decision reads the reference to "deterioration" to mean that every "sign" of deterioration that might signify a resident is dying should be reported. Park Manor, on the other hand, reasonably interpreted the regulation to mean that, where it had already consulted with a physician about a clinical complication and other signs of deterioration that indicated that the resident was dying, it was not required to consult again if the signs and symptoms were the same or were consistent with the change in status already reported to the physician and if the facility made a reasonable judgment that the sign or symptom did not signify a potential need for any further medical intervention that would be consistent with the resident's wishes. The ALJ also refers to the resident's *signs* as "life-threatening," but the regulation defines a significant change as a "deterioration of the resident's status in a life-threatening condition" (such as a heart attack or stroke). While the need for assistance in ambulating, lethargy, and mottling may be signs of or result from "life-threatening conditions," one cannot determine whether they evidence a significant *change* in the resident's physical *status* without examining the circumstances.

context of the requirement and its regulatory history in as great a detail. Ultimately, our decision that Park Manor made a reasonable nursing judgment that none of the signs and symptoms on which CMS relied constituted a significant change in the resident's status rested primarily on our different analysis of what the record showed regarding the resident's status prior to and at the time of the last consultation with the physician late Friday evening.

With respect to the facts, we conclude that CMS had a reasonable basis for its position, both at the time of its initial determination and later.[18] The SOD for the March survey included a finding that the only notification to the physician was the initial notification of the UTI and a finding that the facility had not notified the legal guardian, as required. As discussed above, CMS does not have a duty to investigate the facts asserted in an SOD prior to taking an enforcement action, contrary to what Park Manor asserts. Thus, we find that CMS had a reasonable basis in fact for its initial determination, relying in part on these findings in the SOD as a basis for imposing remedies.

---

[18] We recognize that the statement of "facts" in the ALJ EAJA Decision contains some errors. For example, the ALJ EAJA Decision refers to a failure to consult over a four-day period, which is inaccurate. Also, contrary to what the ALJ stated, the record does contain evidence about the resident's wishes. (See evidence cited in DAB No. 1926, at 5.)

In arguing that CMS's position was not substantially justified, Park Manor focuses mainly on our conclusion that CMS had not made a prima facie showing of a potential for more than minimal harm from the lack of immediate notification after the mottling appeared. This conclusion does not necessarily mean that CMS was not substantially justified in pressing forward with its case on this tag, however. CMS was relying on the CMS surveyor's opinion on symptoms other than the mottling as evidencing significant changes, including what the surveyor saw as a failure to respond to the antibiotic prescribed for the UTI. The CMS surveyor also relied on the resident's need for assistance with ambulation and his lethargy, which the ALJ also found to be significant changes in light of the fact that the resident had been assessed as "ambulatory" at the time of his last comprehensive assessment.[19] While we concluded that Park Manor could have made a different reasonable judgment, given other evidence in the record regarding pre-existing declines in the resident's abilities and energy level and in light of the resident's status at the

[19] The resident assessment instrument (RAI) for January 2001 indicates that he could walk independently in his room, but also that he needed supervision for transfers and when off the unit, that he had fallen within the prior 30 days, and that, for some functions, he was either totally dependent on staff or required extensive assistance. CMS Ex. 12, at 2-3. CMS was not unreasonable in relying on the RAI for some indication of the resident's status, even though we ultimately credited Park Manor's evidence showing that his status had declined between the January RAI and the March events at issue here.

last time the physician was updated on Friday evening, that evidence was not so conclusive, nor the flaws in the surveyor's opinion so apparent, that CMS was unreasonable in going forward to hearing.[20] Moreover, the problem with the lack of evidence regarding the alleged potential for more than minimal harm to the resident from failure to notify the physician of the mottling was not readily apparent without considering the resident's wishes for comfort measures only and evaluating whether the record contained any evidence the resident was in pain or discomfort.

At the hearing, CMS elicited testimony (on which it then relied in its post-hearing brief) that it read as

---

[20] As we noted in our merits decision, the ALJ found Park Manor's witnesses to be credible, but not persuasive. Our evaluation took into account that these witnesses had greater experience in long-term care than the CMS surveyor, several of them were personally familiar with the resident, and their statements were corroborated by the written record and the legal guardian. While their written direct testimony contained information key to our decision, their statements were sufficiently general that CMS could reasonably seek to test them through cross-examination. Some flaws in the CMS surveyor's opinion, moreover, were not readily apparent until cross-examination. For example, on cross she admitted that antibiotics do not work immediately and that the resident's need for help with ambulating was consistent with having a UTI (Tr. at 68-69), which undercut her view that Park Manor should have consulted on alternative treatments for his UTI when he continued to run a fever and that his need for assistance was a significant change.

showing that a resident *would* suffer pain and discomfort from a UTI, a "high" fever, and difficulty breathing and, therefore, as showing that the resident had suffered actual harm (although the testimony, carefully read, merely indicates that these *could* be associated with pain or discomfort). The Board noted the lack of evidence from the resident's medical record that in fact he was suffering, and the contrary evidence from his legal guardian, but again, the weakness in CMS's evidence was not so apparent that CMS was unreasonable in going forward, especially given that CMS was not relying on this tag alone to support the CMP.[21]

In its post-hearing submission, CMS also relied on what it viewed as concessions it had elicited from some of Park Manor's witnesses on cross-examination, including their part ownership interest in the facility, which it could have reasonably thought undercut their credibility. In addition, CMS sought to

---

[21] We also noted that the physician, after being contacted on Monday, March 5, did not order any new treatment (which undercut CMS's position that, if called sooner, he may have adjusted the medication for the UTI or otherwise found ways of alleviating any discomfort the resident was experiencing). In the EAJA proceeding, both CMS and the ALJ questioned the basis for this finding. Page 4 of Appendix I to CMS's post-hearing brief, however, lists as an undisputed fact that the physician had "issued no additional orders" after being contacted on March 5. CMS did seek at and after the hearing to introduce evidence that might have raised questions about whether to draw any inference in Park Manor's favor from this lack of new orders, but the ALJ rejected this evidence on procedural grounds.

introduce evidence from the transcript of the state hearing that CMS thought undercut the testimony of Park Manor's witnesses who appeared before the ALJ in the federal proceeding. Park Manor had opposed admission of this evidence, but the ALJ deferred ruling on the objection until after receiving the post-hearing briefs. Although the ALJ ultimately did not admit this evidence into the record (*see* ALJ Merits Decision at 3-4), CMS was not unreasonable in thinking that the ALJ might admit it. While Park Manor pointed out in reply to CMS's post-hearing brief that CMS had taken part of the state hearing testimony out of context, CMS's reliance on this evidence became a moot issue after the ALJ declined to admit it.

We next turn to the other tags on which the ALJ held a hearing. For those tags, we have, as indicated above, determined that the ALJ's analysis was insufficient under the EAJA. Because those tags (unlike tag F157 from the March survey) were not addressed in any merits decision, we necessarily provide more detail in our analysis than would otherwise be required. Our conclusions are not, however, merits conclusions based on the weight of the evidence.

b. F279

Tag F279 relates to 42 C.F.R. § 483.20(k)(1), which requires a facility "to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that

are identified in the comprehensive assessment." The plan "must describe . . . [t]he services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25." 42 C.F.R. § 483.20(k)(1)(i). The purpose of the care planning requirement is to ensure that a resident receives the services essential to meet his assessed needs and to help the resident achieve or maintain his "highest practicable" level of well-being. *See* section 1819(b)(2) of the Act. The SOD made findings under tag F279 regarding the care of five residents. CMS Ex. 4, at 26-34. CMS presented evidence regarding one of those five residents, Resident 12. In addition, CMS introduced evidence regarding a sixth resident, Resident 19. Although we reviewed CMS's position on Resident 19 and find it reasonable, we discuss only CMS's position on Resident 12.[22]

CMS contended that Park Manor had violated section 483.20(k)(1) because Resident 12's plan of care contained no measures to address his problem of inadequate fluid intake. Resident 12 was 88 years old at the time of the survey and suffered from Alzheimer's type dementia. CMS Ex. 20, at 1. He was

[22] Park Manor's care of Resident 19 is also at issue under tag F309, discussed below. In its summary judgment motion, Park Manor argued that the allegations regarding Resident 19 could not serve as a basis for noncompliance with section 483.20(k)(1) because they were not set out under tag F279 in the SOD. The ALJ rejected this argument. R. 59, at 10-11.

5'2" tall, and his ideal body weight was 115 pounds. CMS Ex. 21, at 3. In November 2000, he experienced an acute episode of dehydration. CMS Ex. 17, at 4. In response, his physician ordered intravenous fluids. *Id.; see also* CMS Ex. 23, at 1 (entries for December 1).

In early December 2000, a Park Manor dietician, Jennifer Timm, wrote that Resident 12 was "nutritionally at risk" due to "potential for dehydration," inadequate food intake, and low body weight. CMS Ex. 23, at 1. According to Timm, Resident 12 did not like to be bothered by staff to eat at or between meals, and although she had talked with him about "drinking more fluids to avoid dehydration and weak/confused feelings," he "did not appear to care much." *Id.*

Treatment notes indicate that the nursing staff regularly encouraged Resident 12 to drink fluids. CMS Ex. 23, at 1. The notes also indicate that he had a strong personality and sometimes became upset or agitated when he was encouraged to do things he did not want to do. *Id.* Timm cited his dementia and depression as factors that impaired his willingness to consume adequate food and liquids. CMS Ex. 21, at 3-4.

At some point between January 6 and 10, 2001, Park Manor completed a comprehensive assessment of Resident 12. *See* CMS Exs. 18-19. The apparent reason for the assessment was that Resident 12 had experienced a "significant change in status." CMS Ex.

18, at 1 (item 8). As part of the assessment, Timm reviewed Resident 12's nutritional status, noting that he had suffered a 9.2% weight loss over the past month "despite all staff efforts to encourage increased intake."[23] CMS Ex. 21, at 3. She estimated his fluid needs at 1500 cc. per day and wrote that "[f]luid intake is often poor, causing potential for dehydration." *Id.* at 3-4.

The regulations require that a comprehensive assessment be completed using the "resident assessment instrument" (RAI) specified by the state. 42 C.F.R. § 483.20(b)(1). The RAI used here was the "CMS-designated" RAI, consisting of three basic components: the Minimum Data Set Version 2.0 (MDS), the Resident Assessment Protocols (RAPs), and the RAI Version 2.0 Manual (RAI Manual). 42 C.F.R. § 483.15. In states using this RAI, a facility must complete an MDS form (CMS Ex. 18) to collect and report information about the resident's functional capacity and then use RAP guidelines to identify and assess problems that might require care planning (CMS Ex. 19). *Id.* The RAPs address a minimum of 18 "domains," each covering a broad subject related to patient health, well-being, or treatment; one of these domains is "dehydration/fluid maintenance". 42 C.F.R.

---

[23] According to a CMS exhibit, Timm's review of Resident 12's status was recorded on January 4, 2001. CMS Ex. 21, at 3. The heading that precedes her review states: "DIETICIAN NOTE: SIGNIFICANT CHANGE IN CONDITION ASSESSMENT." *Id.*

§ 483.315(f). A problem is targeted for evaluation or assessment under a particular RAP based on certain "trigger" conditions identified in the MDS or elsewhere.

In section J of the MDS form, the facility is instructed to note any "indicators of fluid status" that manifested themselves during the previous seven days (unless a different time frame is indicated). CMS Ex. 18, at 3. One of these indicators is "Dehydrated; output exceeds input." *Id.* Another "fluid status" indicator is "Insufficient fluid; did NOT consume all/almost all liquids provided during LAST 3 DAYS." CMS Ex. 18, at 3.

In January 2001, Park Manor completed a MDS form as part of Resident 12's comprehensive assessment. CMS Ex. 18, at 5. In that form Park Manor did not check the "Dehydrated; output exceeds input" indicator in section J. *Id.* at 3. Nor did it check the "Insufficient fluid" indicator. *Id.*

In addition to completing the MDS form, Park Manor prepared a "Resident Assessment Protocol [RAP] Summary" for Resident 12. CMS Ex. 19. This RAP summary lists the 18 RAP "problem areas" (including "dehydration/fluid maintenance" and "nutritional status") and indicates which areas were "triggered" as requiring further assessment. CMS Ex. 19. According to this RAP summary, nutritional status was a triggered problem area, but dehydration/fluid maintenance was not. *Id.*, at 2

In February 2001, Park Manor began to record Resident 12's fluid intake each shift.[24] PM Ex. 8, at 1-2. On February 1, 2001, Nurse Wendy Barbeln wrote in the nurses notes that Resident 12 was showing signs of dehydration and noted that his fluid intake was 1140 cc. CMS Ex. 23, at 9; *see also* PM Ex. 8, at 1 (showing intake of 1140 cc. on the 7:00 a.m. to 3:00 p.m. shift, and 1500 cc. overall for February 1). On February 3, 2001, another nurse wrote that Resident 12 had consumed only 120 cc. of water at supper and that he "continue[d] to need encouragement to drink fluids[.]" CMS Ex. 23, at 9; *but see* PM Ex. 8, at 1 (showing intake of 360 cc. on the 7:00 a.m. to 3:00 p.m. shift, 240 cc. on the 3:00 p.m. to 11:00 p.m. shift, and a total intake of 1000 cc. on February 3).

On February 6, 2001, at Nurse Barbeln's request, Dr. Funk, the attending physician, assessed Resident 12 and "agreed that [he] was dehydrated." CMS Ex. 23, at 9; Tr. at 172. The treatment notes indicate that Dr. Funk instructed the nursing staff to "continue pushing fluids" but decided not to restart IV therapy because Resident 12 was "anxious and frustrated" during the previous infusion and kept pulling the IV out of his arm. CMS Ex. 23, at 9.

---

[24] Nurse Wendy Barbeln testified that the recording of Resident 12's fluid intake began in January 2001, *see* PM Ex. 56, ¶¶ 17, 20, but there is no documentary evidence that the nursing staff gathered this information prior to February 2001.

On March 7-9, 2001, Resident 12 had bouts of diarrhea. CMS Ex. 23, at 10. On March 20, 2001, a "potential for dehydration" was noted in his chart. *Id.* at 12. Resident 12's daily fluid intake in February and March 2001 ranged from a high of 1500 cc. to a low of 180 cc., and in March his daily fluid intake was consistently below 1000 cc., exceeding 600 cc. only three times. PM Ex. 8, at 1-2.

Under the heading "alteration in nutrition," the plan of care in effect for Resident 12 during March 2001 addressed the problem of inadequate food intake and consequent weight loss with specific instructions. CMS Ex. 20, at 2. The plan of care said nothing about Resident 12's potential for dehydration, however. Nor did it set any fluid intake goals.

Jan Suzuki, a licensed dietician with a bachelor's degree in nutrition and medical dietetics, testified on behalf of CMS. CMS Ex. 55. She testified that the nursing records (CMS Exhibits 17-24) "tell me that Park Manor assessed [Resident 12] to be at risk for dehydration." *Id.*, ¶ 12. She further stated that, given Resident 12's "recent history as documented in Park Manor's records," her opinion was that "dehydration should have been triggered as a concern for care planning." *Id.*, ¶ 13. In addition, Suzuki testified that Park Manor did not devise a care plan designed to address Resident 12's need for hydration:

> The care plans I reviewed . . . do not specify goals or approaches for avoiding dehydration. They do not indicate how much fluid he

> should consume on a daily basis, or what staff interventions should be used to encourage him to drink more fluids, or what kinds of beverages he prefers, or how much fluid he should receive at each meal, or what foods should be offered that are high in fluid content.

Id., ¶ 15. Suzuki noted that "dehydration" is categorized as a health concern in the MDS, distinct from questions of nutritional status. *Id.*, ¶ 15. She stated that Park Manor's failure to address Resident 12's need for fluids in the plan of care "had the potential for more than minimal harm because without a care plan to prevent dehydration the resident is at greater risk for recurrence of dehydration." *Id.*, ¶ 16.

In their affidavits, Park Manor's witnesses testified that it was difficult at times to get Resident 12 to take fluids. *See, e.g.*, PM Ex. 56, ¶ 8 (Barbeln); PM Ex. 74, ¶¶ 8-10 (Timm). Most described him as someone who ate or drank only what he wanted and when he wanted to. *See, e.g.*, PM Ex. 63, ¶ 18. They also testified that he was offered food and fluids "on contact" but that he would sometimes refuse the offer if approached in the wrong way or at the wrong time. PM Ex. 56, ¶ 11; PM Ex. 68, ¶ 31; PM Ex. 71, at 7; PM Ex. 74, ¶ 10.

Jennifer Timm (Park Manor's dietician) and others testified that it "was not necessary to care plan for a problem of dehydration . . . because dehydration had not been triggered as a problem in the comprehensive MDS assessment and RAP summary." PM

Ex. 74, ¶ 16 (Timm); PM Ex. 63, ¶ 16 (Haegerl). These witnesses also asserted that as used in a plan of care, the terms "meals" and "nutrition" refer to "food and fluids," and that Resident 12's hydration needs were addressed in the care plan under the problem heading of "alteration in nutrition." PM Ex. 74, ¶¶ 14, 16; PM Ex. 63, ¶ 17. In addition, Park Manor's witnesses noted that the nursing staff was aware of Resident 12's hydration needs, that his food and fluid intake were monitored at each meal, and that fluid intake was recorded on his medication administration record. PM Ex. 63, ¶ 17; PM Ex. 74, ¶¶ 16-17.

At the hearing, Mary Jane Merkely-Zimmerman, a Park Manor certified dietary services manager, admitted that Resident 12 was at high risk of dehydration. Tr. at 218. In addition, Karen Haegerl, a facility nurse, admitted that in early 2001 Resident 12 had signs of, and risk factors for, dehydration, including lethargy and diarrhea. Tr. at 171. Each of these witnesses also admitted that Resident 12's plan of care did not articulate any specific or particular approach for getting Resident 12 to increase his fluid intake or to prevent dehydration. Tr. at 173-175, 218. Nurse Haegerl conceded that "pushing fluids" did not constitute an "individualized" plan of care. Tr. at 175-76.

Considering the whole record, we find that CMS had a reasonable basis for alleging noncompliance with section 483.20(k)(1) in the care of Resident 12. There was evidence – specifically, Jennifer Timm's

January 4, 2001 nutrition status report – that inadequate fluid intake had been identified as a problem during Resident 12's comprehensive assessment. CMS Ex. 21, at 3-4. However, in March 2001, Resident 12's plan of care did not expressly mention this problem, and some of Park Manor's witnesses conceded that the plan did not set forth a specific approach to mitigate the risk of dehydration. That risk was not insignificant or speculative. Resident 12 had been treated for dehydration only four months before the survey. Facility records indicate that in early 2001, Resident 12's fluid intake was often below his estimated daily need, and nursing notes from this period reflect concerns that he was dehydrated or at risk for dehydration.

Park Manor's witnesses stressed that the nursing staff was aware of Resident 12's need to consume more fluids and encouraged him to drink fluids at every opportunity. Nurse Haegerl admitted, however, that Resident 12 enjoyed certain liquids only at certain times and that there was no plan about when it was a good time to offer particular liquids. Given this testimony, and the evidence that Resident 12 often did not accept the nursing staff's entreaties to increase his consumption, CMS could reasonably argue (as it did) that the general approach of "pushing fluids" – or providing fluids "on contact" – was no substitute for careful care planning designed to meet Resident 12's individual needs.

In this appeal, Park Manor contends that it did not violate section 483.20(k)(1) because dehydration

was not identified in the documents from the comprehensive assessment. PM Reply at 27-28. Park Manor also asserts that there were too few RAP "risk factors" present to trigger dehydration as a "problem" for care planning, and that the MDS and the RAP summary did not identify dehydration as a care planning problem. PM Reply at 27-28.[25]

Even if the risk factors for "dehydration" triggering a RAP were not present, however, CMS could reasonably take the position that there were indicators of inadequate fluid intake and therefore a *risk of* dehydration, for which Park Manor should have planned. Section 483.20(k)(1) requires a facility to formulate a care plan for needs identified by a "comprehensive assessment." CMS could reasonably read that regulation as not limiting a facility's care planning obligations only to problems or needs a facility in fact notes on the MDS form and uses a RAP to assess. *See* 42 C.F.R. § 483.20(b)(1) (requiring a facility to perform a comprehensive assessment "*using* the

---

[25] Park Manor had submitted MDS instructions telling a facility to check the box for the dehydration indicator if *two or more* of the following conditions exist:

- "Resident usually takes in less than the recommended 2500 ml of fluids daily (water or liquids in beverages, and water in food)."
- "Resident has clinical signs of dehydration."
- "Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement)."

PM Ex. 7, at 1.

resident assessment instrument" (emphasis added) and requiring the assessment to cover "at least" 18 domains).[26] Otherwise, a facility could avoid its obligation to provide services simply by failing to report an assessment accurately on the RAI. Our conclusion that CMS's reading is reasonable is supported by the Board's recent decision in *Maine Veterans' Home-Scarborough*, DAB No. 1975 (2005), in which the Board concluded that the MDS and RAPs are merely tools to assist a facility and not the exclusive means of identifying resident needs or problems during a comprehensive assessment. We also note here that Resident 12's problem with fluid intake continued to manifest itself in the weeks after the assessment.

Park Manor argues that CMS produced insufficient evidence that the alleged deficiency created the potential for more than minimal harm, asserting that Jan Suzuki was unqualified to give an opinion on the issue. PM Reply at 30. CMS reasonably considered Suzuki to be qualified. *See* CMS Ex. 55, ¶¶ 1-3. Even disregarding Suzuki's opinion, however, the record contains more than adequate evidence from which one could reasonably infer the potential for "more than minimal" harm.

In sum, CMS had a reasonable basis for contending that Park Manor was not in substantial compliance

---

[26] Nurse Haegerl admitted that the nursing staff must formulate a care plan for problems that are not covered by the MDS or RAPs if doing so is clinically warranted. Tr. at 173.

with section 483.20(k)(1) based on the evidence regarding Resident 12.

c. F309

Tag F309 relates to 42 C.F.R. § 483.25, which requires a facility to ensure that each resident receives "the necessary care and services to attain or maintain [the resident's] highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." CMS contended that Park Manor violated section 483.25 by failing to supervise Resident 19 adequately to ensure that he did not choke or aspirate his food or liquids. R. 86, at 22-25. Aspiration occurs when food or liquid enters the airway, and aspiration of foreign matter into the lungs can lead to aspiration pneumonia. CMS Ex. 30, at 3.

The record reveals the following undisputed facts. Resident 19 was admitted to Park Manor on August 25, 2000. PM Ex. 15, at 1. His diagnoses included aspiration syndrome, dysphagia (difficulty swallowing), and Alzheimer's disease and dementia. *Id.*; CMS Ex. 25, at 3, 6; CMS Ex. 27, at 1, 4; CMS Ex. 28, at 2; CMS Ex. 30, at 3. Just prior to admission, he had been treated in the hospital for aspiration syndrome and pneumonia. CMS Ex. 27, at 1. An August 30 nursing note states that Resident 19 coughed "at times" when eating. PM Ex. 15, at 3. During his comprehensive assessment, a facility staff member noted that Resident 19 "may forget to swallow." CMS

Ex. 28, at 2; *see also* CMS Ex. 65, at 11 (nursing notes to same effect); Tr. at 33, 41. His diet in the facility called for "mechanically altered" or "general house ground texture" food as well as thickened liquids, except for water and coffee. CMS Ex. 29, at 3; PM Ex. 15, at 2-3 (entries for August 30); PM Ex. 74, ¶ 21; PM Ex. 71, ¶ 7.

When admitted to the facility, Resident 19 could not feed himself without substantial assistance. *See, e.g.,* PM Ex. 15, at 1, 3. His ability to feed himself apparently improved during the course of his stay. *Id.* at 22; PM Ex. 74, ¶¶ 21-23. On March 7, 2001, the nursing staff noted that he needed only "setup help," "standby assistance," and "verbal cues" from the staff during his meals. PM Ex. 15, at 22.

Because of his dementia, dysphagia, and need for assistance during meals, Resident 19 ate his meals in a supervised eating group in the dining room of the facility's Alzheimer's wing. PM Ex. 15, at 3; PM Ex. 71, ¶ 4; PM Ex. 74, ¶ 21, 23. According to certified nursing assistants who supervised residents in this group –

> Resident 19 preferred to eat on his own, rather than being fed by staff and he was to be allowed to begin each meal on his own, but was to be watched by staff and reminded to follow aspiration precautions. Sometimes because of his physical condition, he would become tired and unable to completely finish his meal on his own, and at that point, the

> CNAs were to step in and see if he wanted any assistance to finish his meal.

PM Ex. 58, ¶ 8; *see also* PM Ex. 64, ¶ 13. Jennifer Timm, Park Manor's dietician, testified that "verbal cueing was sometimes necessary to remind [Resident 19] to take smaller bites and sips, chew more thoroughly and to eat or drink more slowly." PM Ex. 74, ¶ 24.

On January 13, 2001, Resident 19 was admitted to the hospital for aspiration pneumonia. PM Ex. 15, at 15. When he returned to Park Manor, he was assessed by a nurse who observed him eating a meal and who determined that he had "no problems with chewing, swallowing, no coughing during meal." *Id.* The nurse who made the assessment indicated that "aspiration precautions" had been taken during the meal. *Id.*

Jennifer Timm testified that Park Manor's nurses and dietary staff were trained to use aspiration precautions. PM Ex. 74, ¶ 19. She further testified:

> It was routine and a standard of practice that both the nursing and dietary disciplines would routinely observe residents who received any type of thickened liquids, or who were assigned to the Park West supervised dining room for their meals. This is done to insure that aspiration precautions are followed and to determine if diet modifications are needed or, if a resident does not tolerate

> certain foods, if appropriate changes can be made.

Id., ¶ 20. Mary Jane Merkely-Zimmerman testified that Resident 19's need for aspiration precautions was noted on his dietary card and recalled that the card contained instructions for aspiration precautions. PM Ex. 71, ¶ 9.

CMS's allegation of noncompliance was based largely on the testimony of Jan Suzuki regarding her observations of Resident 19 in the dining room between 7:35 and 8:10 a.m. on March 20, 2001. Her self-described "minute-by-minute" observations that morning are recorded in her handwritten notes. CMS Ex. 10, at 44-45.

In her declaration, Suzuki noted what she considered to be two problems with Resident 19's care on the morning of March 20. CMS Ex. 55, ¶¶ 24-26, 28-29. The first was that Resident 19 had been given a food item that was, in Suzuki's opinion, not consistent with his prescription for a "ground texture" diet. *Id.*, ¶ 26. The second (and the one on which CMS focused its presentation) was that staff in the dining room did not adequately safeguard Resident 19 from choking on or aspirating his food. Suzuki testified that Resident 19 was coughing during his breakfast, and that "[w]hen he spoke he made gurgly sounds in his throat that in my professional judgment are associated with aspiration." CMS Ex. 55, ¶ 25. Suzuki's notes state that she observed Resident 19 "gurgling" and coughing at 7:44 a.m. CMS Ex. 10, at 44.

Suzuki explained that "verbal cuing" is a "method of instructing a cognitively impaired resident while eating, to remind him to chew, swallow, or take small bites, as indicated." CMS Ex. 55, ¶ 28. She asserted that the first time she saw Resident 19 being verbally cued on March 20 was at 7:53 a.m., when a certified nursing assistant gave him water and instructed him to "drink it slow" and to "slow down." *Id.*

Suzuki further stated that she observed staff encouraging Resident 19 to continue eating even though he was coughing. She described this as dangerous, opining that "given the severity and duration of [Resident 19's] coughing that I observed . . . , as well as the gurgling sounds I heard, at that time it would have been advisable to cease offering him food and fluids to prevent choking." CMS Ex. 55, ¶ 29. In addition, Suzuki noted that for about two minutes, beginning at 7:58 a.m., there was no nursing staff in the dining room where Resident 19 was eating breakfast. *Id.*, ¶ 30. In Suzuki's opinion, "staff should have been present at all times to ensure that [Resident 19] did not choke on any of the foods and fluids on his tray[.]" *Id.*

Finally, Suzuki asserted that Park Manor had "failed to do a comprehensive assessment of [Resident 19's] swallowing ability and those foods and fluids he could swallow safely or to develop a comprehensive care plan for his aspiration syndrome with methods to reduce his risk of aspiration." CMS Ex. 55, ¶ 31.

At the hearing, Suzuki testified that she saw Resident 19 continue to eat while coughing and take a bite of food while chewed food was still in his mouth. Tr. at 44. She also testified that Resident 19's cough was not strong enough to clear food that might get stuck in his airway, and that he could not consistently "cough and clear his throat independently." Tr. at 33, 57. In view of these factors, it was, in Suzuki's opinion, important that the nursing staff be present to verbally cue Resident 19 (remind him to chew, swallow, or take small bites) during meals to prevent choking or aspiration. Tr. at 57; *see also* CMS Ex. 55, ¶ 28. Park Manor's witness, Jenean Erickson, admitted that it was "possible" that Resident 19 would choke if left to his own devices while eating.[27] Tr. at 210.

A speech pathologist named Tom Olson evaluated Resident 19's swallowing ability in June 1999, after Resident 19 reportedly choked on various foods at

---

[27] CMS also relied on a nursing note describing how Resident 19 ate his breakfast on the morning after surveyor Suzuki's observations. CMS Ex. 65, at 11. The note indicates that Resident 19 needed "cueing not to eat or drink quickly as he did want to take another drink or eat another bite either before he had swallowed what was in his mouth or before he had completely swallowed." When reminded to swallow, Resident 19 stated, "Oh you know that's just my Alzheimers kicking in and I forgot." The note also indicates that Resident 19 was at times trying not to cough, but was told he should cough to ensure he cleared his throat.

home.[28] PM Ex. 17, at 1. At the State hearing, Olson explained his findings and described the "bedside evaluation" on which the findings were based. CMS Ex. 53, at 5, 7-10, 12-13. Olson found that Resident 19's swallowing problem was "severe." *Id.* at 32-33. Olson reported that Resident 19 pooled thin liquids, which was manifested by "a small, a slight gurgling in the throat upon breathing." *Id.* at 55. Olson also found that Resident 19 "had a very weak cough" when he coughed voluntarily in an effort to clear away or expel aspirated liquids or food particles. *Id.* at 56-57. Olson stated that Resident 19's swallowing ability could be expected to worsen. *Id.* at 32-33, 77.

In its post-hearing brief, CMS argued that because of Resident 19's swallowing disorder, dementia, risk for aspiration, and partial ability to feed himself, adequate supervision and verbal cuing were services needed to maintain his well-being. R. 86, at 22-24. CMS further contended that Resident 19 did not receive these services on March 20, noting that the nursing staff had encouraged Resident 19 to continue eating while he coughed, provided virtually no verbal cuing, and left him alone with food outside the presence of staff, increasing the risk that he might choke on or aspirate the food.[29] *Id.* CMS asserted that it was

---

[28] Park Manor submitted Mr. Olson's report as an exhibit, but none of its witnesses testified that he was familiar with the report, or that it was used to care plan for Resident 19.

[29] Although Jan Suzuki faulted Park Manor for providing Resident 19 with food that was, in her opinion, inconsistent with

(Continued on following page)

unsafe for Resident 19 to ingest any food or fluids unless staff was available to remind him to chew and swallow, to cough when necessary to clear his throat, and to stop eating while coughing. R. 88, at 15.

Considering the whole record, we find that CMS had a reasonable basis for alleging noncompliance with section 483.25. Based on the evidence, CMS could reasonably argue that Resident 19 was at risk of aspirating his food and needed staff to remind him to swallow, to eat slowly, and to clear his throat when necessary, and that the supervision in the dining room on March 20 was inadequate. Surveyor Susuki's testimony, if credited, shows that staff provided virtually no verbal cuing despite Resident 19's coughing and "gurgling," improperly told him to continue eating while he was coughing, and left him in the dining room alone.

Park Manor's witnesses testified that it "would not have been necessary for a nursing assistant to sit at a table with Resident No. 19 on a one-on-one basis if he was in a supervised feeding group," and that it

---

his diet and for failing to perform a "comprehensive" assessment of Resident 19's swallowing ability or to develop a care plan for the aspiration risk, CMS did not rely on these opinions for its post-hearing argument on tag F309. Instead, CMS argued that Park Manor was not in substantial compliance with section 483.25 because it failed to supervise Resident 19 adequately during his meal and provide verbal cuing. R. 86, at 22-24. Because we find that this argument had a reasonable basis, we need not address the other EAJA arguments made by Park Manor related to tag F309.

"was adequate if the staff kept Resident No. 19 within visual and hearing contact during the course of the meal." *See, e.g.*, PM Ex. 74, ¶¶ 23, 27. Yet, none of the witnesses asserted that the verbal cuing observed by Suzuki was adequate under the circumstances, that it was safe to leave Resident 19 alone in the dining room, or that staff outside the dining room could actually maintain "visual and hearing contact" with residents inside.

In this appeal, Park Manor contends that CMS failed to make a *prima facie* showing of noncompliance because its evidence failed to establish that Resident 19's care was inconsistent with physician orders, the plan of care, or "professionally accepted standards." PM Reply at 32. However, Park Manor points to nothing in section 483.25 limiting a facility's obligation to provide "necessary services" to services required by a plan of care, physician's order, or "professionally accepted" standard. Board decisions have, in fact, rejected such a narrow application of section 483.25. *See, e.g., Harmony Court*, DAB No. 1968, at 8 (2005) ("the mere fact that [the facility] did not specify in the resident's plan of care that the monitoring would be done is not sufficient to show" compliance with section 483.25); *The Windsor House*, DAB No. 1942, at 19-20 (2004) (noting that section 483.25's overarching purpose is to ensure that residents receive services that ensure favorable health outcomes). Section 483.25 requires a facility to ensure that a resident receives services "necessary" to "attain or maintain the highest practicable physical,

mental, and psychosocial well-being" of the resident.[30] In this case, CMS presented evidence that verbal cuing and close supervision during meals were necessary to prevent choking and aspiration and thereby ensure Resident 19's well-being. CMS also presented evidence that Resident 19 did not receive these services in adequate measure on March 20.

Emphasizing that Jan Suzuki had not worked in a long-term nursing facility, Park Manor asserts that she was not qualified to determine if its nursing care met professional standards, to state that Resident 19's "gurgling sounds" were associated with aspiration, to assert that encouraging Resident 19 to eat while coughing could lead to choking, or to assert that the presence of staff was necessary to ensure that Resident 19 did not choke. PM Reply at 35-36. Although Suzuki had not worked in a nursing facility, she did work as a clinical dietician in the cardiac, surgical, rehabilitation, and oncology units of a hospital. CMS Ex. 55, ¶ 2. She testified that during her tenure at the hospital, she spent five years working closely with a speech language pathologist managing residents with swallowing difficulties. Tr. at 55. She also testified that her degree in nutrition and

[30] Although section 483.25 states that the services must be "in accordance with the comprehensive assessment and plan of care," the Board has concluded that this phrase cannot reasonably be interpreted to limit the facility's obligation to provide needed services, given the history and context of the regulation. *Spring Meadows Health Care Center*, DAB No. 1966 (2005).

medical dietetics included "the study of the physiology, anatomy, different kinds of health conditions, disease states, different age groups, different living conditions, whether it is in a health institutionalized setting versus out patient versus living at home, counseling, performing assessments, making recommendations to other health care professionals including physicians." *Id.* In addition, Suzuki testified that her continuing education included attending seminars on dysphagia. *Id.* None of Park Manor's witnesses testified that Suzuki was unqualified to render the opinions she did, and none questioned her interpretation or assessment of what she observed on the morning of March 20 (*e.g.*, her opinion that Resident 19's gurgling was a sign of aspiration). Under the circumstances, CMS reasonably relied on Suzuki's testimony.

Finally, Park Manor contends that there was insufficient evidence of the potential for more than minimal harm. PM Reply at 36-37. CMS had a reasonable basis to contend that Park Manor's noncompliance created a potential for more than minimal harm, however. Jan Suzuki gave uncontradicted testimony that the practices she observed on March 20 created a risk that Resident 19 might choke on or aspirate his food. Resident 19 had, moreover, recently been hospitalized with aspiration pneumonia.

Accordingly, we find that CMS had a reasonable basis for alleging noncompliance with section 483.25.

d. F332

Tag F332 relates to 42 C.F.R. § 483.25(m)(1), which provides that a facility "must ensure that . . . [i]t is free of medication error rates of five percent or greater[.]" A companion provision requires the facility to ensure that residents are free from "significant" medication errors. 45 C.F.R. § 483.25(m)(2).

In the rulemaking that adopted section 483.25(m), CMS stated:

> Since medication errors vary in their significance . . . , we have based sanctions on two different criteria. First, if a facility has a significant medication error, then it is sanctioned. This policy satisfies consumers, who maintain that a five percent tolerance in medication errors is too lenient and that one medication error could be disastrous for a resident. Second, a facility is sanctioned if it has an error rate of five percent or greater. This satisfies providers who maintain that there must be some tolerance of errors because all systems have some errors. *The five percent limit on medication errors applies to both significant and non-significant errors. When a facility experiences a five percent or greater medication error rate, even if all errors are insignificant, it is a sign that the system has flaws that may eventually lead to a significant, perhaps disastrous error.*

56 Fed. Reg. 48,826, 48,853 (Sept. 26, 1991) (emphasis added).

CMS's *Guidance to Surveyors – Long-Term Care Facilities* (CMS Guidance), an appendix to the State Operations Manual (SOM), defines a "medication error" as –

> The observed preparation or administration of drugs or biologicals which is not in accordance with:
>
> 6. Physician's orders;
>
> 7. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the drug or biological;
>
> 8. Accepted professional standards and principles which apply to professionals providing services.

SOM, App. PP, at PP-129.[31] According to the CMS Guidance, "[a]ccepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils." *Id.*

---

[31] We cite to the paper-based version of the SOM that was in use during 2001 (CMS Pub. 7). In 2004, CMS issued an electronic version of the SOM (Pub. No. 100-07) that supplants the paper-based version. We note that CMS cited the SOM in its arguments to the ALJ during the merits proceeding, and that Park Manor did not challenge the accuracy or relevance of the citations or claim that it lacked pre-survey notice of the SOM provisions.

The CMS Guidance provides that the error rate is calculated by dividing the total number of errors observed by the survey team by the total number of "opportunities for error." SOM, App. PP, at PP-130. An "opportunity for error" is a medication dose that is administered to the resident or an ordered dose that is not administered. *Id.*

CMS's *Survey Procedures for Long Term Care Facilities* (Survey Procedures), another SOM appendix, instruct the survey team to "[i]nitially observe a minimum of 20-25 opportunities for errors" and "[s]trive to observe as many individuals administering medications as possible." SOM, App. P, at P-61. The Survey Procedures instruct the team to observe another 20-25 opportunities for error if one or more errors is found in the initial round of observations. *Id.*

Wanda Hardges, R.N., a CMS nurse consultant who accompanied State surveyors on the March survey, testified that during "medication passes" on March 15 and 16, Park Manor was found to have 11 medication errors out of 59 opportunities for error, an error rate of 18.6 percent.[32] CMS Ex. 54, ¶¶ 21-31. (CMS later conceded that the number of opportunities for error was 60. R. 86, at 27.) Hardges described

[32] Nurse Hardges stated in her declaration that the "opportunities for error" included the "total number [of] all doses observed by the survey team to be administered plus all doses which were ordered but not administered." CMS Ex. 54, ¶ 30. According to Hardges, 25 opportunities for error were observed on March 15, and 34 on March 16. *Id.*

what she considered to be Park Manor's 11 medication errors on March 15 and 16. CMS Ex. 54, ¶¶ 22-29. Three of the errors she described involved administering insulin; the remaining eight involved inhaled medication.

Regarding the three alleged insulin errors, Hardges testified that "accepted nursing standards" call for administering "short-acting" insulin 15 to 30 minutes before a meal, and "intermediate-acting" insulin 30-60 minutes before a meal. CMS Ex. 54, ¶¶ 24, 27. Hardges testified that on March 15, three instances were observed in which Park Manor made a "medication timing error" by failing to administer insulin in accordance with the accepted nursing standards. *Id.*, ¶¶ 23-27. She also testified that these errors created a risk that the residents might suffer a hypoglycemic reaction. *Id.*, ¶¶ 25-27.

The other eight alleged errors were instances in which a nurse failed to wait 60 seconds between puffs when administering multiple puffs of inhaled medication. CMS Ex. 54, ¶¶ 28-29. Nurse Hardges testified that she personally observed one of these errors on March 15, that the other seven errors were observed and reported to her by State surveyors, and that in none of the instances did the nurse wait longer than 15 seconds between puffs. *Id.* Hardges testified that failing to wait at least one minute between puffs was contrary to the "accepted nursing standard," citing an American Society of Consultant Pharmacists (ASCP) publication entitled *Medication Guide for the Long Term Care Nurse* (ASCP Guide). CMS Ex. 54, ¶ 28.

The ASCP Guide contains a section on inhaled medications such as corticosteroids and bronchodilators, instructing caregivers to "[w]ait one minute between 'puffs' for multiple inhalations of the same drug" and noting that "spacing and proper sequence of different inhalers is important for maximal drug effectiveness." CMS Ex. 42, at 3. Hardges testified that if inhaled medication is not allowed sufficient time to penetrate the lungs between puffs, the medication is dissipated, and the resident does not receive the full benefit of the medication. CMS Ex. 54, ¶ 28.

Three of the alleged inhaled medication errors involved the drug Azmacort, a corticosteroid.[33] CMS Ex. 54, ¶¶ 28-29. CMS relied on the manufacturer's instructions (for periods starting in 1995) for Azmacort, which advised the user to wait one minute between puffs. CMS Exs. 62-64. CMS also pointed out that the CMS Guidance lists as a medication error the failure to wait approximately one minute between multiple puffs of medication administered via "metered dose inhalers." SOM, App. PP, at PP-135.3.

Paula Kock, Park Manor's nursing administrator, testified that she was unaware of any one-minute standard or requirement. PM Ex. 68, ¶ 66. She stated: "Other than what occurred in this survey, I have never

[33] The other alleged errors involved Serevent (a bronchodilator), Flovent (a corticosteroid), and Atrovent (a bronchodilator). CMS Ex. 54, ¶ 29.

before or since read or heard of any independent nursing practice which indicates that a nurse is required to wait a full minute between administering successive 'puffs' of the same inhaled medication." *Id.* She asserted that a 15-second waiting time was consistent with accepted nursing practice. *Id.*, ¶ 68. She also asserted that Azmacort instructions specifying a pause of 60 seconds between puffs did not arrive at Park Manor until many months after the survey. *Id.*, ¶¶ 67-68 (citing PM Exs. 24 and 25). Park Manor's consultant Jenean Erickson testified that there was no consistent standard, as evidenced by the fact the SOD cited a 30-second standard. PM Ex. 61, ¶ 70. She also said that manufacturers' recommendations are different from "manufacturers' specifications." *Id.*

Considering the whole record, we find that CMS had a reasonable basis for alleging noncompliance with section 483.25(m)(1), based solely on its evidence concerning the administration of inhaled medication.[34] The ASCP Guide, issued by a national organization, instructs a nurse to wait one minute between puffs of commonly prescribed inhaled medication; no exceptions or qualifications are noted. The package insert for Azmacort contains the same clear instruction. According to the CMS Guidance, the ASCP

[34] Given this conclusion, we find it unnecessary to discuss the alleged insulin errors, although our review of the record persuades us that CMS could reasonably contend that Park Manor committed at least one timing error in administering insulin.

guidelines and the manufacturer's specifications are the type of evidence that should be considered authoritative by surveyors in deciding whether a medication "error" has occurred. Moreover, even if Park Manor was not aware of these instructions or considered them merely recommendations, the CMS Guidance itself indicates that failure to wait about one minute between puffs is a medication error. CMS could reasonably rely on this evidence about the standard, especially since Park Manor presented no documentary evidence that 15 seconds was the commonly accepted professional standard.

CMS presented evidence – including "Medication Pass Worksheets" (CMS Exhibits 32-33) and the declaration of Wanda Hardges – that, on eight occasions, Park Manor nurses failed to wait at least one minute when administering multiple puffs of an inhaled medication to a resident. In other words, CMS presented evidence of eight medication errors involving inhaled medication. Eight errors in 60 opportunities for error yields an error rate of 13.3%, well above the five percent threshold. Given Hardges' unrebutted testimony that a resident would not get the full benefit of the medication if the wait time were less than one minute and that the surveyors said they observed three different nurses waiting only 15 seconds or less, for a total of eight such observations, CMS reasonably argued that there was a systemic flaw in Park Manor's medication administration procedures that created the potential for more than minimal harm.

In the EAJA appeal, Park Manor makes a number of assertions about CMS's case-in-chief, none of which causes us to question its reasonableness. First, Park Manor asserts that CMS's position was fatally compromised by reliance on hearsay evidence – namely, the reports of surveyors who did not testify. PM Reply at 37. We do not agree. Hearsay is admissible in these cases and may constitute substantial evidence of the facts asserted if it has sufficient indicia of reliability. *Florence Park Care Center*, DAB No. 1931 (2004), citing *Richardson v. Perales*, 402 U.S. 389 (1971). With respect to the inhaled medication errors, the surveyor's observations were reported to (and described by) Nurse Hardges in her direct testimony. CMS Ex. 54, ¶¶ 28-29. These reports had some indicia of reliability. Park Manor did not attempt to secure, by subpoena or otherwise, the testimony of the surveyors or of the facility employees involved in these incidents. The staff who were observed were presumably in the best position to challenge the accuracy or veracity of the surveyors' reports. Well before the hearing, Park Manor was aware that CMS intended to rely on the surveyors' observations but never sought to exclude the evidence of those observations on the ground that surveyors were unavailable. In addition, the observations described by Hardges are corroborated by the written reports of the surveyors in official survey documents – e.g., Medication Pass Worksheets (CMS Exhibits 32-33) and the SOD (CMS Exhibit 4, at 67-70) – all of which would arguably qualify for admission under the Federal Rules of Evidence hearsay exception for

records or reports of public agencies, absent circumstances indicating their untrustworthiness. *Guardian Health Care Center*, DAB No. 1943, at 16, n.13 (2004).

Park Manor asserts that the hearsay was unreliable because the surveyors were "biased." PM Brief at 38, *citing* PM Exs. 79A-83B. We have examined the exhibits cited by Park Manor to support this allegation but find no evidence that surveyor bias tainted the reported observations. Under the circumstances, CMS reasonably relied on the observations reported by Nurse Hardges.

Next, Park Manor contends that CMS "failed to introduce any evidence tending to show that the standards, against which it sought to measure Park Manor's practices, was either a doctor's order, a manufacturer's specification, or a commonly accepted health standard established by a national professional organization, board, or council." PM Reply at 37. As we have just explained, however, CMS did introduce such evidence for the inhaled medication incidents.

Park Manor also contends that CMS failed to authenticate or validate the "sample" of observations upon which CMS based its allegations. PM Reply at 37-38. It also asserts that CMS failed to introduce any "credible evidence of how many observations constituted the sample on which the calculation was based." *Id.* CMS could reasonably rely on the evidence it did as establishing the medication error rate, however. As the Board pointed out in *Pacific Regency*

Arvin, DAB No. 1823, at 11 (2002), the SOM uses CMS's longstanding definition of the term "medication error rate" (the number of errors observed divided by the opportunities for error times 100), and nothing in the regulation requires CMS to address the statistical significance of its findings as part of its *prima facie* case of noncompliance. Moreover, Nurse Hardges did explain how the surveyors arrived at the number of observations (by counting doses administered and doses ordered but not administered). CMS Ex. 54, ¶ 30. This testimony is corroborated by the medication pass worksheets completed by the surveyors. CMS Exs. 32-33. These worksheets document the 59 observations that Hardges refers to in her testimony, and cross-examination of Hardges did not show that the number of observations was any larger than 60. Tr. at 78-91. Whether the total number of observations is 59, 60, or 100, CMS could reasonably claim that the error rate was greater than five percent based on the number of inhaled medication errors alone.

Finally, Park Manor asserts that the Azmacort administration errors were "the result of differences between what may have been the instructions in the packages," which Park Manor claims it had not yet received, "and the directions in the PDR [Physicians' Desk Reference], which was used at Park Manor as a medication reference." PM Reply at 40. Park Manor had failed to produce the relevant portions of the PDR on which it claimed to rely, however. Thus, we

see no reason why CMS needed to account for this assertion.

e. F496

Tag F496 relates to 42 C.F.R. § 483.75(e)(5), which states in pertinent part:

> Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless –
>
> (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or
>
> (ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry.

Section 483.75 implements section 1819(b)(5) of the Act, which prohibits a facility from employing as a nurse aide any person who has not completed a state-approved training and competency evaluation program (NATCEP). The purpose is to ensure that nurse aides have the education, practical knowledge, and skills needed to care for facility residents. 56 Fed. Reg. 48,880 (Sept. 26, 1991). A state-approved training program must include "supervised practical training," in which a trainee "demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a

licensed practical nurse." 42 C.F.R. § 483.152(a)(3). States must maintain a registry of nurse aides who satisfactorily complete the required education and training. Section 1819(e)(2) of the Act.

The record contains evidence of the following facts.[35] On February 27, 2001, Park Manor hired Ron Reeder to work as a nurse aide. At Park Manor, a nurse aide's duties include assisting residents with bathing, dressing, oral hygiene, feeding, toileting, turning and repositioning, and restorative care. Reeder began working at Park Manor on March 2, 2001. He received some training during his first two weeks of employment. The training consisted of four hours of video instruction and 10 days working beside – and under the direct supervision of – a certified nursing assistant named Jeanette Ryback. Ryback provided Reeder with on-the-job skills training and, at the end of the training period, certified that he had achieved the necessary degree of proficiency in performing certain nurse aide duties.

The training Reeder received was not part of an approved NATCEP. According to Karen Haegerl, whose duties at the facility included serving as an instructor in its approved nurse aide training program, a NATCEP must be run by registered nurses who themselves receive training on how to train

[35] This recitation of background facts is drawn from the following sources: CMS Ex. 4, at 79-80; CMS Exs. 46-51; CMS Ex. 56, ¶¶ 4-11; Tr. at 147-157, 179, 185, 194; PM Exs. 33, 84-88.

others. Park Manor's approved NATCEP required 40 hours of classroom instruction and 40 hours of clinical practice as a prerequisite for certification. Jeanette Ryback, Reeder's trainer, was not a registered nurse and had no training as an instructor in the State-approved NATCEP.

On or about March 15, 2001, Reeder began to perform his duties independently of his trainer, providing the full range of nurse aide services to eight residents. On March 22, 2001, Park Manor's nursing home administrator informed surveyors that Reeder had no nurse aide certification and was not then enrolled or participating in an approved training program. Reeder did not start the approved training program until after the survey.

These facts, none of which Park Manor disputed, show that beginning in early March 2001, Park Manor allowed a person who was not then on Wisconsin's nurse aide registry, had not recently completed an approved NATCEP, and was not then enrolled in or actively participating in an approved NATCEP to work in the facility as a nurse aide. The plain language of section 483.75(e)(5) expressly prohibits a facility from using a person as a nurse aide under these circumstances.

Park Manor does not allege that it was complying with section 483.75(e)(5), but contends that CMS was not justified in alleging noncompliance because CMS failed to introduce any evidence of a potential for

more than minimal harm. PM Reply at 41. We do not agree that such evidence was lacking.

During the proceeding, CMS presented written direct testimony from state surveyor Barbara Brock Arndt. CMS Ex. 56. She did not directly state an opinion that this deficiency had a potential for more than minimal harm. She did, however, refer to the competency requirements under the statutory scheme and state law, describe her findings on aspects of Reeder's training and supervision (which on their face are inconsistent with these requirements or otherwise questionable), and describe her findings regarding the activities in which he was engaged shortly after being employed, without even a CNA to supervise him. She also stated her opinion that Reeder was "employed by the facility to provide direct nursing services to residents without being properly trained to provide such services." *Id.* at ¶ 12. One could reasonably infer from this evidence that there was a potential for more than minimal harm. At the hearing, moreover, CMS elicited testimony from Karen Haegerl, a supervising nurse at Park Manor, that the approved training program would have been better able than Reeder's trainer to instruct a trainee about spotting problems with a resident's condition. Tr. at 160-161. In addition, Haegerl admitted that a nurse aide trainee would not learn everything he needed to know about proper body positioning without taking the approved training course. Tr. at 164-65. Haegerl also testified that Reeder would be less able to detect a significant change in a resident's

condition than a person who participated in state-approved training. Tr. at 186, 192-193.

Park Manor submitted a checklist completed by Jeanette Ryback that indicates that Reeder had demonstrated proficiency in a number of nurse aide skills between March 2 and March 14, 2001. PM Ex. 85. However, Park Manor made no attempt to show that Reeder's training was comparable to an approved NATCEP. Ryback's checklist does not confirm that Reeder received all the required training. For example, the required curriculum includes training in meeting residents' mental health and social services needs and in communicating and understanding the needs of cognitively impaired residents. 42 C.F.R. 483.152(b)(4) and (5). The checklist does not indicate that Reeder received any training in these areas, yet Park Manor provided no evidence that the eight residents Reeder cared for did not have any such needs.

Given the undisputed facts, a fact-finder could reasonably infer that Park Manor's failure to comply with section 483.75(e) created the potential for more than minimal harm to residents, especially to the eight residents under Reeder's care.

Park Manor asserts that CMS goes too far in arguing here that the fact that Congress required NATCEP training in order to protect and promote resident health and safety means that *any* failure to comply with the requirement *automatically* poses a potential for more than minimal harm. PM Reply at

41. In fact, however, CMS was not relying solely on the failure to meet the requirements, but also on the extent and nature of the failure.

Accordingly, we conclude that CMS had a reasonable basis for alleging noncompliance with section 483.75(e).

f. F444

Tag F444 relates to 42 C.F.R. § 483.65(b)(3), which states: "The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice." In the rulemaking that promulgated this section, CMS explained:

> We are also introducing a requirement at § 483.65(b)(3) for handwashing by staff with direct resident contact when indicated by accepted professional practice. Our purpose in doing so is to state in more specific terms the basic intent of a requirement that we originally proposed at § 483.65(a)(5). This provision, as proposed, would have required all personnel to follow aseptic and isolation techniques in accordance with acceptable professional practice. We are revising this requirement to focus on handwashing by staff with direct resident contact when indicated by accepted professional practice, in view of recent studies that have identified such handwashing as one of the basic, essential measures for preventing the spread of infection in nursing homes. We will use the

> Guideline for Handwashing and Hospital Environmental Control, 1985, published by the Centers for Disease Control of the Public Health Service, as the standard for accepted professional practice in this area.

54 Fed. Reg. 5316, 5345 (Feb. 2, 1989).

CMS's evidence regarding tag F444 consisted largely of statements by Wanda Hardges, the CMS nurse consultant who accompanied WDHFS surveyors during the March survey.[36] CMS Ex. 54. In written direct testimony, Nurse Hardges stated that, on March 15, 2001, she watched Park Manor nurse Pat Witt administer insulin to four residents. *Id.* ¶ 32. According to Hardges, Witt "did not wash her hands either with water or a hand sanitizer before and after administering the insulin injections to each" of the four residents. *Id.* Hardges stated that this omission was "contrary to accepted professional practice, which requires that a nurse wash his or her hands before and after administering an injection to each patient, using either soap and water or a liquid sanitizer." *Id.*

---

[36] Surveyors reported that Park Manor had a written policy entitled "Infection Control – Prevention Policy and Procedure." CMS Ex. 4, at 74. According to the SOD, this policy stated: "The MOST important factor in infection control is handwashing. . . . Handwashing will be done as promptly and thoroughly as possible between resident contacts and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them." *Id.* Neither party submitted a copy of the policy, or any evidence about whether its contents adequately reflected "accepted professional practice" for handwashing.

Nurse Hardges further stated that on March 20, 2001, she observed a physical therapist administer ultrasound treatment to Resident 17. CMS Ex. 54, ¶ 33. According to Hardges, the therapist entered the room with ultrasound equipment in a carrying case, removed a leg wrap from the case, and put on gloves without first washing his hands. *Id.* The therapist then applied gel to the resident's legs and wrapped them in preparation for administering the ultrasound treatment. *Id.* Hardges stated that the therapist's failure to wash his hands before putting on gloves to administer treatment was "contrary to accepted professional practice which requires staff to wash their hands before putting on gloves to give direct care." *Id.* ¶ 34. In support, she pointed to a guideline adopted by the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), a national organization. *Id.* The APIC guideline, entitled *Guideline for Hand Washing and Hand Antisepsis in Health-Care Settings*, states that gloves should be used in addition to, not as a substitute for, handwashing. *Id.* (citing CMS Ex. 44, at 12). Hardges stated that the "APIC recommends this guideline because of the problem with leakage of microbial contamination from latex and vinyl gloves and possible transmission of infection even when gloves are worn." *Id.* CMS also submitted a copy of a handwashing guideline published by the Centers for Disease Control, entitled *Guideline for Handwashing and Hospital Environmental Control, 1985*. CMS Ex. 43.

Finally, Nurse Hardges stated that she observed what she considered to be a failure to adhere to accepted professional practices during a wound dressing change:

> On March 15, 2001, at 9:40 a.m., I accompanied state surveyor Barbara Brock-Arndt in observing Park's nurse, Sherri Vanish, change the dressing on a resident's legs. Paula Kock, Park's Director of Nursing, was also present. Both of the resident's legs were wrapped with dressing from the knee to the ankle. After Nurse Vanish removed the dressing, she did not follow the proper nursing practice of removing her gloves, washing her hands and putting on new gloves before putting on the clean dressing. Rather, she continued to wear the same gloves without washing her hands after removing the old dressing and putting on the new dressing. The resident had stasis ulcers on both her legs: there were open areas on each leg, and the legs were red and swollen.

CMS Ex. 54, ¶ 35.[37]

In its summary judgment motion, Park Manor made no attempt to rebut Nurse Hardges' opinion that she had witnessed failures to follow accepted

---

[37] Nurse Hardges described other incidents, related to administering eye drops and assisting with food trays, but did not specify that they were departures from accepted nursing practice. The issues Park Manor raised about these incidents were an inconsequential part of the proceedings.

nursing standards regarding handwashing. Nor did Park Manor attempt to dispute any of the factual assertions supporting that opinion. Instead, Park Manor argued that section 483.65(b)(3) does not make the facility responsible for discrete or specific instances in which an employee fails to follow accepted professional handwashing practices. R. 47, at 23. According to Park Manor, the regulation merely calls on the facility to require its staff to follow such practices. *Id.* at 23-24. Consequently, Park Manor said, the incidents described by Hardges did not constitute a violation of section 483.65(b). *Id.*

In granting partial summary judgment to Park Manor, the ALJ found that section 483.65(b)(3) does not make a facility responsible for incidences of substandard care but merely directs a facility to "enforce" a handwashing policy. R. 59, at 13. The ALJ acknowledged that a "pattern of violations of handwashing policy might be proof from which I could infer that the facility was not enforcing a policy or that it had no policy." *Id.* But here, he said, "the evidence consists of a few observations which CMS has not linked to a pattern of noncompliance." *Id.* He concluded that Hardges' "few observations" were insufficient proof that Park Manor was not enforcing its handwashing policy. *Id.*

CMS's position, of course, was that the incidents described by Nurse Hardges were sufficient evidence of noncompliance with section 483.65(b)(3). R. 52, at 19-20. In support of that position, CMS argues that the regulation can reasonably be read to hold the

facility responsible for instances in which employees fail to live up to professional standards regarding handwashing. CMS Response at 47. We agree that this is a reasonable interpretation. Section 483.65(b)(3) states that a facility must "*require* staff to wash their hands after each direct resident contact" when accepted nursing standards require this practice. The word "require" can reasonably be read as meaning that the facility must do something more than merely adopt a handwashing policy. Unless a facility takes steps to ensure that its handwashing policy is actually and consistently followed by facility staff, the goal of controlling infection cannot be met.

The introductory language in section 483.65 further supports CMS's argument. This language, which describes the general standard that the facility must meet in controlling infection, states that a facility must not only "establish" but "maintain" an infection control program, and that this program must be "designed" to achieve certain outcomes – namely, a "safe, sanitary, and comfortable environment" and the prevention of disease and infection. Given its focus on health outcomes, the regulation can reasonably be read as requiring the facility to implement an effective infection control program in their daily interaction with residents.

CMS's argument is also consistent with statements made in the preambles to the proposed and final rules enacting section 483.65. The final rule indicates that section 483.65(b)(3) was adopted to "state in more specific terms the basic intent of a

requirement that [CMS] originally proposed" in section 483.65(a)(5). 54 Fed. Reg. 5316 (Feb. 2, 1989). The preamble to the proposed rule explained section 483.65(a)(5) as follows:

> [W]e would not require [in section 483.65(a)(5)] that the facility have written effective procedures for aseptic and isolation techniques. Instead, we would specify that the *facility must ensure that aseptic and isolation techniques are followed* by all personnel, in accordance with acceptable professional practice. This shifts the emphasis from paper compliance to an outcome orientation based on current professional standards.

52 Fed. Reg. 38582 (Oct. 16, 1997) (emphasis added).

In addition, we find that CMS had a reasonable basis in fact for asserting noncompliance at the summary judgment stage. CMS proffered direct testimony from Nurse Hardges that three employees failed to wash their hands when professional standards required them to do so. It also produced documentary evidence of those standards. Park Manor's summary judgment motion offered no contradictory evidence or opinion or, for that matter, any explanation for the alleged lapses.[38]

---

[38] Shortly after moving for summary judgment, Park Manor filed an affidavit by Paula Kock, who stated that she was present during the dressing changes Hardges observed. Kock asserted that she and the other nurse who was present changed gloves and washed their hands "at all appropriate stages of the

(Continued on following page)

Park Manor suggests that because CMS did not rely on the introductory language in section 483.65(b)(3) in opposing the motion for summary judgment, CMS is now defending a position that it did not take before. PM Reply at 23. We find no merit to this argument. The position that CMS took before is the one that it is defending now – namely, that section 483.65(b)(3) requires facility staff to perform handwashing in accordance with accepted professional practices, and that its evidence was sufficient to support a finding of noncompliance under that section.

Park Manor also contends that CMS's evidence does not establish a breach of professional standards because CMS did not expressly allege that employees did not wash their hands between patient contacts or after contact with blood, body fluids, or contaminated articles. PM Reply at 24. However, with respect to the incidents involving the injections and wound dressing change, such allegations can reasonably be inferred from Nurse Hardges' statements. In the first, Nurse Hardges reported that a nurse had failed to wash her hands between injections given to different patients.

---

dressing changes" and suggested that Hardges was not present during the entire procedure and therefore did not witness their handwashing. PM Ex. 68, ¶¶ 70-72. At best, these statements reveal that Hardges and Kock had differing recollections of the relevant events and that a hearing was necessary to resolve the dispute. At that stage of the proceeding, there was no other evidence corroborating Kock's account. Thus, CMS was reasonable in pressing forward based on Hardges' testimony.

CMS Ex. 54, ¶ 32. In the second, Hardges asserted that handwashing should have been done while changing dressings on leg wounds, implying that this was necessary because of contact with dressings contaminated by open wounds. *Id.* ¶ 35.

Finally, Park Manor contends that because it had a written handwashing policy, quoted in the SOD, CMS could not reasonably argue that it was not in substantial compliance with section 483.65(b)(3). PM Reply at 23-25. As we have said, however, the regulation can reasonably be read to require more than adopting a policy. Moreover, Park Manor did not produce a copy of the policy or introduce evidence suggesting that it had taken reasonable and adequate steps to enforce the policy.

We note that we are addressing only whether CMS had a reasonable basis for its position at the summary judgment stage of the proceeding. We also note that the incidents described by Hardges were not trivial or insignificant. Two of the incidents involved nurses who were directly administering treatment. One involved a nurse who allegedly failed to wash her hands in the course of administering injections to four different residents. Another allegedly occurred in the presence of Park Manor's nursing director. Given these circumstances and the ALJ's obligation at the summary judgment stage to view the evidence in the light most favorable to CMS, we conclude that CMS reasonably opposed the summary judgment motion with respect to Tag F144.

5. *CMS's position that Park Manor was subject to remedies based on the June revisit survey was not substantially justified, and there are no special circumstances that make an award with respect to that matter unjust.*

As discussed in section B.2 above, we must determine whether CMS's position that Park Manor was subject to remedies based on the June revisit survey was substantially justified and, if not, whether special circumstances make an award with respect to that matter unjust. Below, after reviewing some relevant background information, we explain why we conclude that CMS did not show that (1) its position on that matter was substantially justified or (2) special circumstances make an award for costs associated with that matter unjust.

The June revisit survey yielded findings under six tags. In July 2001, CMS issued a notice advising Park Manor that two remedies were being imposed based on the revisit findings: a continuation of the $250 per day CMP previously imposed as a result of the March survey and a DPNA.

In August 2001, WDHFS issued a revised SOD for the June revisit survey, as a result of IDR, and removed the findings under tag F157. (CMS acknowledges that it received a copy of the revised SOD, but points to a typographical error in an identification number on the revised SOD. The first page of the revised SOD clearly states, however, that the original SOD – cited by number – was withdrawn due to IDR,

and clearly relates to the June 11, 2001 survey of Park Manor. CMS Ex. 60.)

Because of the events occurring at the State level, the parties in the federal proceedings were not required to submit their briefs, exhibits, and written direct testimony until almost a year later. In mid-July 2002, CMS made its submission, stating that it was relying on only one deficiency (tag F157) to support a $100 per day CMP for the period after the June revisit survey. (While CMS did not so state, this also meant that this alleged deficiency was the only remaining basis for the DPNA imposed as a result of the June revisit survey.)

Park Manor's submission was due and was submitted in mid-August, 2002, but Park Manor first moved for summary judgment. In its motion, Park Manor contended, among other things, that the remedies associated with the June revisit survey should be set aside because tag F157 had been rescinded by WDHFS in August 2001 as a result of IDR.

In response to the motion, CMS did not withdraw the remedies imposed as a result of the June revisit survey. Rather, CMS contended that it was not bound by state IDR determinations, and that it had "never adopted" the survey agency's decision to rescind tag F157. R. 52, at 2, 6-7. CMS also claimed that CMS officials were unaware of the rescission prior to the filing of Park Manor's motion. *Id.* at 7. In addition, CMS declared that it was rejecting the IDR determination regarding tag F157 and reaffirming its finding

that Park Manor was not in substantial compliance during the June revisit survey. *Id.* at 8.

In his October 2002 summary judgment ruling, the ALJ found that CMS had the authority to overrule the IDR determination, but that CMS had failed to show that an employee with proper authority had done so. For this reason, the ALJ granted summary judgment to Park Manor with respect to tag F157 and set aside the CMP and DPNA for the period June 11 through July 23, 2001.

In its EAJA application, Park Manor relied on the summary judgment ruling in its favor to support its entitlement to an award. CMS's Answer, however, did not address why CMS defended the remedies based on the June revisit survey findings under tag F157, even after those findings had been withdrawn.

CMS has the burden of showing substantial justification. Yet, CMS does not even contend that it had a reasonable basis for relying on tag F157 from the June revisit survey, despite the IDR result. Because Park Manor was the prevailing party on this matter, CMS was obliged to defend that assertion in this proceeding or risk having to pay an EAJA award for expenses associated with that matter. This was not an inconsequential issue in the proceedings, but had become the determinative issue on the remedies resulting from the June revisit survey. As a result of CMS's assertion, Park Manor was obliged to take significant steps to defend against it, including submitting its arguments, written direct testimony, and

exhibits, before it prevailed on the matter through the ALJ's summary judgment ruling. Moreover, Park Manor specifically argued in the EAJA proceeding, both before the ALJ and before us, that CMS had not made even a *prima facie* showing of noncompliance under tag F157. *See, e.g.*, Park Manor's Reply to CMS Answer at 23-24. Yet, CMS did not and does not respond directly to this argument, much less provide the type of analysis of the legal and factual basis for its substantive position that EAJA requires.

In its brief to the ALJ in the EAJA proceeding, CMS referred to the summary judgment ruling as a "procedural ruling." *See* CMS Answer at 27, n.11. But CMS did not then (and does not now) explain why that would make a difference in an EAJA analysis. Under the regulations, "an applicant has prevailed when the agency has made a final disposition favorable to the applicant with respect to any matter which could have been heard as a separate proceeding, regardless of whether it was joined with other matters for hearing." 45 C.F.R. § 13.22(c). The regulations do not distinguish between favorable dispositions on procedural and substantive grounds.[39]

---

[39] CMS does assert that its failure to challenge the summary judgment ruling is "irrelevant to the issue of substantial justification." CMS Response at 26, n.14. We do not rely on CMS's failure to challenge the ruling as a basis for our substantial justification analysis (although we do not consider it wholly irrelevant). That failure, however, made the summary judgment ruling the final disposition on the matter.

CMS further asserts in a footnote before us that the ALJ had previously upheld CMS's authority to overrule a state IDR determination. CMS Brief at 26, n. 14. Even if CMS has the *authority* to overrule a state IDR determination, however, that does not automatically mean that CMS properly exercised that authority or that it had a reasonable basis for doing so. At the time CMS filed its July 2002 submission stating that it was relying on tag F157, CMS had taken no action to review the evidence or argument that led to the IDR result, much less to overrule that result based on its own findings. In describing the case background to us, CMS reiterates its assertion (first made in response to the summary judgment motion) that it was not "aware" of the IDR results prior to that motion. Even if such unawareness might be understandable in some circumstances, it is hardly an excuse under the particular circumstances here.[40] First, WDHFS had informed CMS of the results almost a year before CMS's key evidentiary submission (to which Park Manor was obliged to respond). Second, CMS does not deny that it was aware that Park Manor had requested IDR on the June revisit survey, aware that many of the findings from the March survey had been rescinded through IDR, and

[40] CMS also seems to fault Park Manor for not informing CMS of the IDR results sooner. However, Park Manor could have reasonably thought that WDHFS would do so, as it did. While Park Manor could have informed CMS through a less formal means than a motion for summary judgment, moreover, CMS's response indicates that this would have made no difference.

aware that the State ALJ had overruled some other findings from the March survey. Third, the whole purpose of IDR is to avoid less formal proceedings for disputes that can be resolved informally.

In any event, CMS fails to make any case that it reasonably defended against the summary judgment motion, *after* learning of the IDR result. As noted above, CMS responded to the motion by asserting that it had "never adopted" the IDR results and by offering noncompliance findings in a declaration made by a CMS employee, who identified herself as the person who makes recommendations on initial determinations. R. 52, at 2, 6-7; CMS Ex. 58, ¶ 2. But CMS did not then and does not now point to anything in the regulations supporting a view that IDR results are contingent on CMS "adopting" them. The regulations provide instead that the result of successful IDR is removal of the deficiencies from the SOD and that, if any enforcement actions are based solely on those deficiencies, the actions are rescinded. 42 C.F.R. § 488.331(c). Here, once WDHFS did issue a revised SOD, removing the findings under tag F157, CMS could no longer reasonably rely on the findings in the initial SOD.

The regulations do provide that, if CMS and a state disagree over findings of noncompliance, CMS's findings regarding a facility that participates in both Medicare and Medicaid take precedence when CMS "finds that [the] facility has not achieved substantial compliance." 42 C.F.R. § 488.452(a)(2). The ALJ therefore held that CMS could make a *finding* to

overrule IDR results, but concluded that the CMS employee on whose declaration CMS relied had no authority to overrule the IDR results. Her own declaration suggests as much, and CMS offered no evidence in the EAJA proceeding that she had such authority.

More important, even if CMS had followed the proper *procedure* to overrule the IDR result, that alone would not be sufficient for CMS to meet its burden to show it had a reasonable basis for its substantive position in the proceeding. The key reason why we grant an EAJA award is that CMS fails to contend that it had a reasonable basis in law and fact for asserting noncompliance under tag F157 as support for the DPNA and the $100 per day CMP.

Accordingly, we conclude that CMS did not meet its burden to show that its position on this matter was substantially justified.

Having reached this conclusion, we must next determine whether "special circumstances" make an award for Park Manor's work on that matter unjust. CMS contends generally that special circumstances exist precluding *any* EAJA award to Park Manor, but asserts that this issue is a factual question that should be resolved initially by the ALJ.[41] CMS Reply at 3-8; CMS Response at 57-58.

---

[41] On May 9, 2005, Park Manor filed a "motion to strike" the arguments on special circumstances CMS made in its reply

(Continued on following page)

Neither the regulations nor the EAJA mandates a remand in these circumstances, nor does Board precedent.[42] Although we would prefer to have an ALJ address a special circumstances issue in the first instance, we find that a remand is not necessary here. The potential award pertains to a narrow part of the merits proceeding, the record is sufficient to permit us to evaluate CMS's contentions in a meaningful way, and the narrow issues we need to resolve do not require us to evaluate the credibility of witnesses or counsel. Moreover, the history of the case and the need to bring it to closure weigh against a remand.

CMS contends that Park Manor's litigation behavior and rejection of good faith settlement offers are special circumstances that justify denial of an EAJA award. Regarding settlement, CMS asserts

---

brief. Because we rule in Park Manor's favor on that issue, we deny this motion as moot.

[42] The EAJA provides that "the adjudicative officer" will determine whether special circumstances make an award unjust, but it does not preclude an agency's appellate authority from making that determination in appropriate circumstances. Federal agencies must establish "uniform procedures for the submission and consideration" of EAJA applications. 5 U.S.C. § 504(c)(1). The HHS regulations do not *require* the Board to remand a case to the ALJ when he or she has failed to make required findings. They provide only that the Board "shall issue a *final decision* on the application . . . or remand to the adjudicative officer for further proceedings." 45 C.F.R. § 13.27. The authority to issue a "final decision" generally includes the authority to modify or supplement an ALJ's findings, and, therefore, our *EAJA Guidelines* interpret the regulation to permit us to do so.

that it offered to settle the case early in the proceeding (in late June 2002), then later (after the ALJ's October 2002 summary judgment ruling) proposed to settle the case for $6,100. According to CMS, Park Manor rejected the settlement offers "out of hand" and made no reasonable counter offer. CMS asserts that Park Manor's settlement proposals in November 2002 included a stipulation that it be denominated the "prevailing party." CMS asserts that it "could not reasonably have been expected to agree to enter into a compromise that would require ongoing litigation over an EAJA application." CMS Answer at 44.

Regarding Park Manor's litigation behavior, CMS asserts that while CMS "tried repeatedly to maintain a sense of proportion in the litigation" (by moving for summary judgment and unilaterally reducing the number of findings at issue), Park Manor "consistently expanded the scope of the litigation" by (1) filing an excessive number of affidavits and state hearing transcripts containing "duplicative," redundant, or "irrelevant" testimony, and (2) unjustifiably withholding transcripts from the State proceeding, requiring CMS to file two motions to compel. CMS Answer at 43-51; CMS Reply at 9-17. CMS also asserts that Park Manor, in defending its failure to produce the contested transcripts, made inaccurate or untrue statements about their nature and content. CMS Answer at 49-51; CMS Reply at 9-15. In addition, CMS contends that Park Manor filed two affidavits by its nursing administrator that contained

"inconsistent statements made under oath." CMS Answer at 51-53; CMS Reply at 18-20.

The term "special circumstances" is not defined in the statute or regulations, and there appears to be scant evidence of its meaning in EAJA's legislative history. *Air Transport Assoc. of Canada v. Fed. Aviation Admin.*, 156 F.3d 1329, 1333 (D.C. Cir. 1998). What evidence there is indicates that the special circumstances provision was intended as a "safety valve" that gives the decision-maker the discretion to deny an award when "'*equitable considerations* dictate an award should not be made.'" *Id.* (quoting from H.R. Rep. No. 1418, 96th Cong., 2d Sess. at 11) (emphasis added); *see also Scarborough v. Principi*, 541 U.S. 401, 423 (2004) (citing and quoting from the same House Report).[43]

One court has observed that the "theme of 'unclean hands' pervades the jurisprudence of 'special circumstances' under EAJA." *Air Transport*, 156 F.3d, at 1333. Traditionally, the doctrine of unclean hands is invoked to bar equitable relief to a party that has engaged in unlawful or inequitable conduct concerning the matter for which it seeks the relief. When applying the doctrine, courts have required a close or actual connection between the alleged misconduct and the claim at issue. *In re New Valley Corp.*, 181 F.3d 517, 525 (3rd Cir. 1999), *cert. denied* 528 U.S.

---

[43] The cited legislative history relates to the analogous "special circumstances" provision in 28 U.S.C. § 2412(d)(1)(A).

1138 (2000); *see also Keystone Driller Co. v. General Excavating Co.*, 290 U.S. 240, 245 (1933) (noting that courts of equity "apply the maxim requiring clean hands only where some unconscionable act of one coming for relief has immediate and necessary relation to the equity that [the party] seeks in respect to the matter in litigation").

Unclean hands appears to be the basis for CMS's special circumstances argument. The argument, in essence, is that Park Manor should not be awarded fees and expenses for litigation that it pursued in bad faith or proceedings that it "unnecessarily multiplied" (CMS Answer at 45). However, the potential award covers only a small segment of the proceeding – namely, the part connected with Park Manor's challenge to tag F157 from the June revisit survey. As discussed, the ALJ resolved that matter on October 8, 2002 by granting summary judgment to Park Manor on tag F157 and setting aside the related remedies. CMS did not appeal the summary judgment ruling. Consequently, the award will, for the most part, be limited to fees and expenses for work performed prior to October 8, 2002 – more specifically, to the fees and expenses incurred in connection with the proceedings to overturn tag F157 and set aside the related remedies.

We find no special circumstances that would justify denying this limited award. The alleged misconduct that CMS describes – including Park Manor's failure to produce the contested State hearing transcripts – has no apparent direct relationship to the

June revisit survey. For example, CMS's contention that one of Park Manor's witnesses made "inconsistent statements under oath" relates to a finding from the March survey. As for CMS's contention that Park Manor unjustifiably failed to turn over transcripts, that issue first surfaced in early September 2002 when CMS filed a motion to compel production of the transcripts. R. 53. The motion to compel was filed after the parties had exchanged briefs supporting or opposing the summary judgment motion that sought to set aside the remedies associated with the June revisit survey. *See* R. 47 and R. 52. There is no indication that Park Manor's refusal to turn over the transcripts at this point resulted in unnecessary or protracted litigation concerning those remedies. Moreover, CMS's assertion that Park Manor filed duplicative, redundant, and irrelevant testimony is at most minimally related to the potential award, given that the summary judgment ruling obviated the need for a hearing on the matter arising from the June revisit survey. In any event, some of CMS's claims regarding irrelevant evidence and obstructive behavior were rejected by the ALJ in the merits proceeding, including CMS's claim that Park Manor willfully ignored an ALJ order by declining to turn over its own transcriptions of testimony from the State hearing. R. 68, at 2; R. 69; Tr. at 126-27. Finally, we do not find that Park Manor's filing of duplicative and redundant testimony is so egregious as to establish unclean hands.

We reject any suggestion that Park Manor's refusal to settle the case is a special circumstance.[44] The settlement negotiations that took place in late June 2002 occurred before CMS submitted its evidence and witness list. Whatever Park Manor's actual reasons for rejecting settlement, Park Manor could reasonably insist on seeing CMS's proof before deciding whether to accept or propose settlement at this stage of the proceedings. To the extent that CMS believes that it was unreasonable not to settle the case because the amount of the penalty was small, we note that Park Manor had the statutory right to contest a CMP of any amount. In addition, it might have had other reasons for going forward. The hearing process may have favorable results for a facility other than overturning a CMP, including avoiding adverse publicity and removing deficiencies from the facility's compliance record, which CMS might consider in selecting remedies in future surveys.

For the foregoing reasons, we find that there are no special circumstances that render the limited EAJA award unjust and that Park Manor is therefore entitled to an award for the reasonable fees and expenses it incurred in connection with the proceeding to overturn the remedies from the June revisit survey.

---

[44] It is difficult to imagine that refusal to settle a case and accept a CMP would ever constitute a special circumstance, given that facilities have a statutory right to a hearing to challenge the imposition of any CMP. *See* 42 U.S.C. §§ 1395i-3 (h)(2)(B)(ii) and 1320a-7(a).

C. Park Manor's request for an EAJA award pursuant to 5 U.S.C. § 504(a)(4)

Park Manor contends that the ALJ erred in finding that it could not recover an award under 5 U.S.C. § 504(a)(4) because it was a "prevailing party." PM Brief at 30-37. According to Park Manor, sections 504(a)(1) and 504(a)(4) of the EAJA provide remedies for different "administrative abuses": section 504(a)(1) authorizes an EAJA award when an agency's position is not substantially justified, and section 504(a)(4) authorizes an award when the penalty demanded by an agency in an enforcement action is excessive. *Id.* at 32. Park Manor argues that these provisions do not provide mutually exclusive avenues of relief for private litigants because it is conceivable that an agency may, in the same case, take a position that is not substantially justified *and* seek a penalty that is excessive or unreasonable. *Id.* at 33. Park Manor also contends that the ALJ erred in concluding that CMS's demand was not excessive or unreasonable. PM Brief at 37-41.

We find it unnecessary to address the ALJ's finding concerning the reasonableness of CMS's demand because we agree with the ALJ that Park Manor was not entitled to an award under section 504(a)(4) as a matter of law.

Section 504(a)(4) states:

> If, in an adversary adjudication arising from an agency action to enforce a party's compliance with a statutory or regulatory requirement, the

> *demand* by the agency is *substantially in excess of the decision* of the adjudicative officer and is *unreasonable* when compared with such decision, under the facts and circumstances of the case, the adjudicative officer shall award to the party the fees and other expenses relating to defending against the excessive demand, unless the party has committed a willful violation of law or otherwise acted in bad faith.

(Emphasis added). "Demand" means the express demand of the agency which led to the proceeding. 5 U.S.C. § 504(b)(1)(F).

HHS's EAJA regulations provide that an award may be made "either on the basis that the Department's position in the proceeding was not substantially justified or on the basis that, in a proceeding to enforce compliance with a statutory or regulatory requirement, the Department's demand substantially exceeded the ultimate decision and was unreasonable when compared with that decision." 45 C.F.R. § 13.5(a). Section 13.5(c) provides that an award may be made on the latter basis "only if the Department's demand that led to the proceeding was substantially in excess of the ultimate decision in the proceeding, and that demand is unreasonable when compared with that decision, given all the facts and circumstances of the case." 45 C.F.R. § 13.5(c)(1). That section also states that an award under the excessive demand provision "shall be limited to the fees and expenses that are primarily related to defending against the excessive nature of the demand," and

"shall not include fees and expenses that are primarily related to defending against the merits of charges, or fees and expenses that are primarily related to defending against the portion of the demand that was not excessive, to the extent that these fees and expenses are distinguishable from the fees and expenses primarily related to defending against the excessive nature of the demand." 45 C.F.R. § 13.5(c)(2).

Viewed in their totality, these provisions envision a situation in which the agency has obtained some measure of the relief it sought by initiating the enforcement action. This is most clearly evident from the requirement that the award be fashioned to exclude (to the extent practicable) fees and expenses associated with the reasonable or justified part of the agency's demand, including costs incurred in defending against the "merits of charges." We therefore find that section 504(a)(4) applies when an enforcement action like this one results in a proceeding that establishes a private party's noncompliance but gives the agency substantially less than what it "demanded" in remedies for that noncompliance. *See American Wrecking Corp.*, 364 F.3d at 327 (noting that the function of the analogous excessive demand provision in 28 U.S.C. § 2412(d)(1)(D) is "merely to permit *non*-prevailing parties to recover fees and expenses where the United States obtained a judgment that was substantially – and unreasonably – exceeded by its initial demand").

In this case, section 504(a)(4) does not apply because CMS did not obtain any part of its initial demand. The provision's inapplicability is apparent from the scope of Park Manor's fee request: Park Manor seeks not merely the limited award permitted by section 13.5(c) – that is, costs associated with the "excessive" portion of a partially justified demand – but *all* of the fees and expenses it would be entitled to receive under section 504(a)(1) as a "prevailing party," including costs associated with its challenge to findings that had a reasonable basis in law and fact.

Park Manor insists that it may recover an award for all of its fees and expenses in the merits proceeding based on the absolute disparity between CMS's initial demand and the outcome of the proceeding.[45] But section 504(a)(4) requires not only that a disparity exist but that the initial demand be "unreasonable." Here, CMS's remedy demands can be considered unreasonable only if CMS's position on which those demands were based was not substantially justified. *See* 142 Cong. Reg. S3242-02, 104th

[45] Park Manor asserts that the statute and regulations required the ALJ to compare CMS's "initial demand" – that is, the remedies initially imposed by CMS following the March and June revisit surveys – with the "final outcome" of the proceeding to determine whether the demand was excessive or unreasonable. Instead of making that comparison, says Park Manor, the ALJ "established a 'rolling standard' of reasonableness in which the demands that the agency made at various stages of the litigation were compared to the remedies which could have been imposed based on the allegations which had survived the litigation process to that point." PM Brief at 38.

Cong., 2d sess. 1996, WL 142887, at 8 (March 29, 1996) (noting that the "test" for applying the provision is "not a simple mathematical comparison" but an assessment of whether the agency's demand "is so far in excess of the true value of the case, as demonstrated by the final outcome, that it appears the agency's assessment or enforcement action *did not represent a reasonable effort to match the penalty to the actual facts and circumstances of the case*)" (italics added).[46] To permit recovery under section 504(a)(4) based solely on the absolute disparity between the initial demand and the outcome would allow Park Manor to circumvent the substantial justification requirement in section 504(a)(1) and to obtain an award merely because CMS's position did not succeed. *American Wrecking Corp.*, 364 F.3d at 327 (noting that the excessive demand provision "surely does not permit [a litigant] to recover a greater amount than it could otherwise recover" under section 504(a)(1)).

D. The FOIA issue

Park Manor contends that the ALJ erred in denying its request to exclude from the public record certain information about the net worth of Park

[46] The excessive demand provision was added to the EAJA in 1996 by section 231 of Public Law 104-121 (110 Stat. 862-863).

Manor and its controlling shareholder. We find that the ALJ did not err in denying this request.

An EAJA applicant is eligible for an award only if its net worth falls below certain limits. 5 U.S.C. § 504(b)(1)(B). To ensure compliance with this eligibility requirement, an EAJA applicant must submit "a detailed exhibit" showing its net worth and the net worth of any "affiliates." 45 C.F.R. § 13.11. This "net worth exhibit" will "ordinarily" be included in the public record of the proceeding unless the applicant shows that the exhibit is exempt from public disclosure under the Freedom of Information Act (FOIA). *Id.* Section 13.11(c) describes how the applicant should make this showing:

> [A]n applicant that objects to public disclosure of information in any portion of the exhibit and believes there are legal grounds for withholding it from disclosure may submit that portion of the exhibit directly to the adjudicative officer in a sealed envelope labeled "Confidential Financial Information," accompanied by a motion to withhold the information from public disclosure. The motion shall describe the information sought to be withheld and *explain, in detail, why it falls within one or more of the specific exemptions from mandatory disclosure under the Freedom of Information Act, 5 U.S.C. 552(b)(1)-(9), why public disclosure of the information would adversely affect the applicant, and why disclosure is not required in the public interest.*

45 C.F.R. § 13.11(c) (emphasis added).

Park Manor's net worth exhibit includes the affidavit of a person who stated that he was the accountant for Park Manor and Park Manor's majority or controlling shareholder. Attached to his affidavit are Park Manor's balance sheets for 2000 and 2001, as well as a one-page document detailing the shareholder's personal assets. With the net worth exhibit, Park Manor filed a motion under FOIA to withhold from public disclosure the accountant's affidavit and attached material. PM EAJA Ex. 10. The motion contained only the following rationale:

> [A]pplicant asserts that the affidavit and attached exhibits contained detailed financial information about the applicant and its affiliate which is of a confidential nature and which is protected from public disclosure by 5 U.S.C. § 552(b)(4). Prior to its submission in this case, this information had been maintained by an affiliate and her accountants in the strictest of confidence. Its disclosure to the public at this time would cause that applicant and its affiliate irreparable injury and the interest of the applicant and the affiliate in continued non-disclosure outweighs any interest of the public in having access to this financial information.

Id. The FOIA exemption claimed by Park Manor, known as "exemption 4," covers "trade secrets and commercial or financial information *obtained from a person* and *privileged or confidential*." 5 U.S.C. § 554(b)(4) (emphasis added).

In denying the motion, the ALJ found that it contained only "conclusions" that parroted statutory and regulatory language and failed to explain how or why the shareholder would be injured by disclosure of the information in the net worth exhibit. ALJ EAJA Decision at 5. Park Manor now insists that its motion was adequate – that to prevent public disclosure, it was sufficient for the motion to demonstrate that financial information was obtained from "a person" who regarded that information as "confidential." PM Brief at 63-64. Park Manor contends that its motion satisfied these criteria by stating that the documents contained "detailed financial information" about its controlling shareholder, information that "'had been maintained by the [shareholder] and her accountants in the strictest of confidence.'" *Id.* at 64 (quoting the motion). Park Manor also contends that the harm or potential harm from disclosure was obvious and "inherent in the situation," and that although its motion did not allege a lack of public interest in disclosure, the public interest would not in fact be served by keeping the documents in the public record because CMS did not challenge its financial eligibility for an EAJA award. *Id.* at 64-65.

We uphold the ALJ's ruling. As the ALJ found, Park Manor's motion failed to provide the detailed explanation required. The motion made no attempt to show that the financial information was exempt from disclosure under FOIA exemption 4 and the case law construing that exemption. In addition, the motion did not explain how Park Manor or its shareholder

would be adversely affected by disclosure, or why disclosure was "not required in the public interest." Finally, the accountant's affidavit does not support the motion. Indeed, the affidavit does not state that the shareholder's financial information was in fact confidential.

E. The amount of the allowable award

Having found Park Manor entitled to an award, we must determine the amount to be awarded. The allowable award covers the litigation-related work that Park Manor performed to overturn the June revisit survey's finding of noncompliance and the related remedies. Park Manor's fee and expense documentation is not detailed enough for us to determine exactly how many attorney and paralegal hours were actually and reasonably spent on that work (or the amount of associated expenses). For example, time summaries from July 2002 use the phrases "work on motion" or "edit and revise motion," or some variation on these words, to describe the work on the summary judgment motion that prompted the ALJ to overturn the remedies based on the June revisit survey. However, that motion also addressed several issues concerning the March survey. Thus, while we could estimate how much of Park Manor's work on the motion concerned issues related to the June revisit survey (and may therefore be allowable), we prefer to have the parties' input before doing so.

The regulations provide that when the proceeding involves "two or more matters, each of which could have been heard separately . . . the fees and expenses shall be shown separately for each proceeding or matter, and the basis for allocating expenses among the proceedings or matters shall be indicated." 45 C.F.R. § 13.12(b). However, given the novelty of applying the EAJA in these cases, we do not think Park Manor can fairly be faulted for not maintaining its documentation to reflect the different matters involved. Since the award should be based on the firmest footing possible, we will give Park Manor an opportunity to provide some reasonable basis for allocating the already documented hours and expenses between the matter arising from June revisit survey and the rest of the proceedings, and give CMS an opportunity to comment and to offer an alternative allocation.

Accordingly, within 30 days of receiving this decision, Park Manor may submit its proposed methodology, with a supporting rationale, and documentation applying that methodology to determine the amount that may be reimbursed under this decision. CMS shall have 30 days from receiving Park Manor's submission to file a response. The Board will then promptly issue a final decision that incorporates all its findings and conclusions regarding this appeal. We encourage the parties to consult with one another during the briefing period to narrow the remaining issues and, if possible, to agree on the amount of the fees or expenses to be awarded.

Should the amount of the allowable award remain disputed after the briefing period, we will apply the following guidelines in resolving the dispute. As HHS's regulations make clear, fees or expenses may be awarded only if they have a direct and necessary connection with the applicant's representation in the proceeding. Section 13.5(b)(3), for example, states that "[a]wards for fees and expenses incurred before the date on which a proceeding was initiated will be made only if the applicant can demonstrate that they were reasonably incurred in preparation for the proceeding." Section 13.7 states that the reasonable cost for any report, study, exhibit, or similar matter may be awarded only if it "was necessary to the preparation for the administrative proceeding."

The burden is on Park Manor to establish the reasonableness of its fee and expense request. *Role Models America, Inc. v. Brownlee*, 353 F.3d 962, 969-70 (D.C. Cir. 2004). Hours that are not adequately documented or that are "excessive, redundant, or otherwise unnecessary" are not reimbursable. *Precision Concrete v. N.L.R.B.*, 362 F.3d 847, 853 (D.C. Cir. 2004) (*quoting Hensley v. Eckerhart*, 461 U.S. 434, 443 (1983)). Time records must be detailed enough to permit an assessment of the reasonableness of the claimed fees and expenses. *Role Models America*, 353 F.3d at 970-73 (discussing various shortcomings with applicant's fee documentation, including inadequate or "generic" descriptions of work performed).

The parties' briefs contain arguments about the allowability of particular claimed fees or expenses

(which should not be repeated in the new submissions). If necessary, we will address those arguments after receiving the parties' new submissions.

Conclusion

Pursuant to 5 U.S.C. § 504(a)(1), Park Manor is entitled to an award for the reasonable fees and expenses incurred in the proceeding to challenge the remedies imposed by CMS based on the June revisit survey. In accordance with the schedule outlined in section E of the Discussion section, the parties may make additional submissions to assist the Board in determining the amount of the award. If necessary, the Board will then issue a final decision that fixes the amount of the award. No other award is appropriate.

Cecilia Sparks Ford

Donald F. Garrett

Judith A. Ballard
Presiding Board Member

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

In the Case of:	
Park Manor Nursing Home	DATE: March 31, 2006
Petitioner,	Civil Remedies CR1263
- v.-	App. Div. Docket No. A-05-37
Centers for Medicare & Medicaid Services.	

Addendum to Board Decision No. 2005

This is an addendum to the Board's December 16, 2005 decision, DAB No. 2005, concerning Park Manor's application for attorney's fees and other expenses under the Equal Access to Justice Act (EAJA). The purpose of this addendum is to determine the amount of reasonable fees and expenses to which Park Manor is entitled under DAB No. 2005, For the reasons below, we award fees of $6,866.

Background

In DAB No. 2005, the Board analyzed whether an EAJA award could be made for one or both of two separate "matters" that had been consolidated for hearing before the ALJ in the underlying merits proceeding. The first matter was Park Manor's appeal

of deficiency findings from a March 2001 standard survey. The second matter was Park Manor's appeal of deficiency findings from a June 2001 revisit survey.

During the merits proceeding, CMS elected to defend only one of six deficiency findings – tag F157 – from the June revisit survey. Park Manor responded, in a motion for summary judgment, that tag F157 had been rescinded during informal dispute resolution (IDR) and thus could not be the basis for an enforcement remedy. On October 8, 2002, the ALJ granted summary judgment to Park Manor on revisit tag F157, thereby overturning the enforcement remedies that CMS had imposed based on the June revisit survey. The ALJ then proceeded to a hearing on the deficiency findings from the March survey. On September 30, 2003, the ALJ issued a decision, upholding a CMP based on one of the March survey's deficiency findings. On June 17, 2004, the Board issued DAB No. 1926, which reversed the ALJ's September 30, 2003 decision and set aside the CMP. On July 15, 2004, Park Manor filed an EAJA application seeking approximately $250,000 in attorney's fees and expenses. On December 28, 2004, the ALJ issued a decision denying the EAJA application in its entirety.

In DAB No. 2005, the Board modified the ALJ's EAJA decision in a number of respects. It found, among other things, that CMS's pursuit of remedies based on revisit tag F157 was not substantially justified. For that and other reasons, the Board concluded that Park Manor was entitled to the "reasonable litigation-related fees and expenses that Park Manor incurred

to overturn the remedies that CMS imposed for noncompliance found" during the June revisit survey. DAB No. 2005, at 75. Because Park Manor's fee and expense documentation failed to differentiate between work on the appeal of the June revisit deficiency findings, and work on the appeal of the March survey findings, the Board postponed a determination about the amount of the award in order to give Park Manor "an opportunity to provide some reasonable basis" for allocating the documented fees and expenses among these two matters. *Id.* We emphasized that Park Manor had the burden to establish the reasonableness of its fee and expense request. *Id.* We also emphasized that excessive or inadequately documented fees are not reimbursable, and that time records must be detailed enough to permit an assessment of the reasonableness of claimed fees and expenses. *Id.*

On January 19, 2006, Park Manor submitted a letter and supporting documentation containing its proposed fee and expense allocation. Based on its proposed allocation, Park Manor requests $47,448.33 for fees and expenses incurred during the underlying merits proceeding, and $72,201.88 for fees and expenses incurred to pursue the EAJA litigation. In response, CMS submitted its own proposed allocation, contending that Park Manor's reasonable fees and expenses are no more than $5,000 to $6,000. In the alternative, CMS urges the Board to deny Park Manor any award on the ground that its EAJA application was filed late with respect to the matter arising from

the June revisit survey. In addition, CMS contends that the award should be zero because, in its view, Park Manor made an exorbitant fee request and failed to propose a reasonable basis for allocating its claimed fees and expenses.

Discussion

A. Timeliness of the EAJA application

Because the EAJA permits an award to the prevailing party only if that party files an application for the award within a specified time period, we must first address CMS's contention that Park Manor's EAJA application was untimely with respect to the "matter" – the appeal of revisit tag F157 – for which it is entitled to reasonable fees and expenses, The EAJA states that an application for attorney's fees and other expenses "shall" be submitted "within thirty days of a *final disposition* in the adversary adjudication[.]" 5 U.S.C. § 504(a)(2) (emphasis added). The statute does not define the term "final disposition."

Section 13.22 of HHS's EAJA regulations implements the 30-day filing requirement. That section provides in relevant part:

> (a) The applicant must file and serve its application no later than 30 calendar days after the Department's *final disposition of the proceeding* which makes the applicant a prevailing party.
>
> (b) For purposes of this rule, *final disposition means the date on which a decision or*

> *order disposing of the merits of the proceeding or any other complete resolution of the proceeding*, such as a settlement or voluntary dismissal, *becomes final and unappealable*, both within the agency and to the courts.
>
> (c) For purposes of this rule, an applicant has prevailed when the agency has made a final disposition favorable to the applicant with respect to any *matter which could have been heard as a separate proceeding*, regardless of whether it was joined with other matters for hearing.

45 C.F.R. § 13.22 (emphasis added),

CMS asserts that the October 8, 2002 summary judgment ruling was the ALJ's "final disposition" regarding the appeal of revisit tag F157. CMS also asserts that because it did not appeal that ruling, the ruling became "final and unappealable" to any tribunal on the 61st day after receipt of the ALJ's September 30, 2003 final decision on the merits. Assuming that CMS received the September 30 decision within 5 calendar days, the 61st day following receipt was December 5, 2003. Thus, according to CMS, in order for Park Manor to obtain fees and expenses for work relating to revisit tag F157, Park Manor had to file an EAJA application no later than January 4, 2004. Park Manor did not file its application until July 14, 2004.

The issue raised by CMS's argument is the proper meaning of the phrase "final disposition of the proceeding" in section 13.22(b). CMS apparently takes

the position that a final disposition has occurred when a ruling disposing of any segregable "matter" in the proceeding has become final and unappealable, even if other matters that were consolidated for hearing and decision in that proceeding have not been finally and completely adjudicated. Section 13.22(b)'s language does not clearly support that position, however. Section 13.22(b) uses the term "final disposition" to refer to the outcome of a "proceeding" (a term not defined by the regulations), rather than resolution of any specific "matter" or claim. Broadly defined, the term "proceeding" means the progression, from beginning to end, of a litigation that may subsume multiple matters or claims, *Cf.* Black's Law Dictionary, 8th ed. (2004) (defining the term "proceeding" as the "regular and orderly progression of a lawsuit, including all acts and events between the time of commencement and the entry of judgment"). If the term "proceeding" is defined in this way, then a final disposition does not occur until *all* matters or issues consolidated for adjudication in a case have become final and unappealable. This view is consistent with section 13.22(b)'s description of a final disposition as something that achieves a "*complete*, resolution" (emphasis added)

CMS provided no legal analysis to support its contrary interpretation of the regulatory language. Nor did it argue that its interpretation is consistent with the underlying statute or the EAJA's purposes. Indeed, in the earlier stages of the EAJA proceeding, CMS did not argue that the application was untimely

with respect to the matters or issues resolved by the ALJ's summary judgment ruling.

Thus, we reject CMS's position that the ALJ's summary judgment ruling on revisit tag F157 was a "final disposition of the proceeding" for purposes of the EAJA's 30-day filing requirement.

Our conclusion here is consistent with the decision in *Phoenix Roofing, Inc. v. Occupational Safety & Health Review* Comm., 922 F.2d 1202 (5th Cir. 1991), where the court addressed the meaning of "final disposition." The circumstances in that case were similar to the ones here. The Department of Labor (DOL) had issued two OSHA citations to a construction firm, Phoenix Roofing (Phoenix), for violating safety regulations. The firm contested both citations before an ALJ. The ALJ affirmed the first citation and dismissed the second. DOL appealed the decision on the first citation to the Fifth Circuit, which affirmed the citation (but reversed the associated civil money penalty). Phoenix then filed an EAJA application with the ALJ. The application sought – and the ALJ awarded – fees and expenses incurred by Phoenix for its work on both citations. DOL then appealed the award made for the second citation, contending that the application for that award was untimely. Specifically, DOL contended that the ALJ's decision to dismiss the second citation became final 30 days after it was docketed, and therefore Phoenix should have filed an EAJA application with respect to that citation within 30 days afterward (or by June 22, 1998),

instead of waiting until after the Fifth Circuit decision on the first citation had become final (in 1999).

The Fifth Circuit rejected this argument, holding that "there is no 'final disposition' of a case until the entire decision is final and unappealable." 922 F.2d at 1207. The court found support for this interpretation in a 1985 amendment to the EAJA that prohibits a decision on a fee application when a government appeal on the merits is pending. *Id.* at 1206, In addition, the court found that its interpretation preserved the general policy of avoiding piecemeal litigation and supported congressional purposes in enacting the EAJA:

> Congress intended to make it easier, not harder, for people of limited means to collect their small claims from the government. Holding that there is no "final disposition" until the entire decision is final and unappealable avoids both the unnecessary fragmentation of the fee petitions and the waste of judicial resources that would result from filing multiple petitions in different courts for fees incurred in one case. Such multiple fee litigation unduly burdens both the litigants and the courts.

Id. at 1207. We agree with this court's reasoning and find that its concerns are relevant here. To the extent that there is ambiguity in the relevant statute and regulation about how the 30-day requirement should be applied in these circumstances, that ambiguity should not be resolved in a way that might create a

"trap for the unwary" EAJA litigant. *Myers v. Sullivan*, 916 F.2d 659, 670 (11th Cir. 1990) (recognizing that the 30-day filing requirement, while jurisdictional, should be "interpreted broadly," avoiding "overtechnical constructions of the requirement").

B. Park Manor's revised request for fees and other expenses

We now determine which of the claimed fees and expenses are reasonable. Before addressing specific elements of Park Manor's proposal, it is necessary to clarify the boundaries of the permissible award. In DAB No. 2005, the Board found that CMS's initial decision to impose remedies based on the June revisit survey was substantially justified. DAB No. 2005, at 21-26, The Board also found that the permissible award was for work that challenged CMS's reliance on revisit tag F157. *Id.* at 66 (stating that the "key reason we grant an EAJA award is that CMS fails to contend that it had a reasonable basis in law and fact for asserting noncompliance under tag F157 as support for the DPNA and the $100 per day CMP"). The clear implication of these findings is that CMS was substantially justified in pursuing remedies based on the June revisit survey up to the point it elected to rely solely on tag F157 from that survey. That election was made on July 15, 2002, when CMS submitted its documentary evidence (including written direct testimony), witness list, and pre-hearing brief. Park Manor does not contend that it learned of the election before then. Because CMS's position regarding the June

revisit remedies did not become unjustified until July 15, 2002, we find that Park Manor is not entitled to compensation for work performed before that date unless there is some credible showing that the work directly and materially supported its post-July 15 effort to overturn revisit tag F157.[1]

That effort consisted primarily of three submissions by Park Manor during the merits proceeding before the ALJ. The first was a July 22, 2002 motion for summary judgment. R. 47. The motion dealt with issues relating to both the March survey and the June revisit survey.[2] The second submission was

---

[1] There is no indication that CMS was less than diligent prior to July 2002 in investigating the merits of the June revisit findings or in coming to a decision about which of those findings to pursue in the merits proceeding. That decision was made before Park Manor was required to submit its exhibits, written direct testimony, and pre-hearing brief.

[2] The brief supporting the summary judgment motion was 43 pages long and did the following: (1) set out the background of the case (pgs. 1-6); (2) asked the ALJ to "dismiss" findings of noncompliance not addressed in CMS's pre-hearing brief, witness declarations, and exhibits (pgs. 6-11); (3) contended that Park Manor was entitled to summary judgment regarding tag F157 from the June revisit survey because the state survey agency had rescinded the tag during IDR in August 2001 (pgs. 11-13); (4) argued that the six deficiency findings from the March survey that CMS had elected to pursue were not adequate to support a remedy (pgs. 13-27); (5) contended that a state ALJ decision precluded CMS, on collateral estoppel grounds, from pursuing some of the deficiency findings from the March survey (pgs. 27-39); and (6) urged the ALJ to set aside the CMP based on the March survey and the CMP based on the

(Continued on following page)

made on August 15, 2002. It contained Park Manor's documentary evidence (including written direct testimony), witness list, and pre-hearing brief. R. 50. These materials supported Park Manor's position regarding all deficiency findings remaining at issue in the case. Finally, on September 12, 2002, Park Manor submitted a brief, affidavits, and other material in order to counter arguments opposing its request for summary judgment regarding revisit tag F157.[3] R. 54.

With this background in mind, we agree with CMS that Park Manor's fee and expense request is excessive or inadequately supported in several respects. The request is documented in four schedules attached to Park Manor's January 19, 2006 letter. Schedules 1 and 2 show fees and expenses incurred during the merits proceeding before the ALJ. Park Manor requests $23,019.82 under Schedule 1 and $24,428.51 under Schedule 2. Schedules 3 and 4 show fees and expenses incurred in the subsequent EAJA proceedings before the ALJ and the Board. Park Manor requests $65,705.06 under Schedule 3 and $6,493.82 under Schedule 4. We discuss the reasonableness of Park Manor's request under each schedule.

June revisit survey, and to issue an order rescinding the loss of its nurse aide training program (pgs. 39-43).

[3] This submission was entitled "Park Manor's Objection and Brief in Response to CMS's Motion to Amend Prehearing Exchange." R. 54. It consisted of a 28-page brief, two affidavits (three and five pages long), and a few pages of exhibits. These materials responded in part to CMS's request to admit additional evidence concerning its reliance on revisit tag F157. R. 52.

1. Schedule 1

a. *Attorney hours*

Schedule 1 lists 153.2 attorney hours. These hours are from the period from June 11, 2001 through October 15, 2002. According to Park Manor, the fees shown on Schedule 1 were "incurred exclusively, or almost exclusively, in investigating and litigating the verification visit [revisit survey] cites, and most specifically tag F157," Jan. 19 Letter at 4. As we indicated, however, fees and expenses incurred *prior to July 15, 2002* are not compensable absent some credible showing that they relate directly to Park Manor's post-July 15 challenge to revisit tag F157. Of the 153.2 attorney hours claimed on Schedule 1, 65.6 hours were for work performed prior to July 15, 2002. The timesheet descriptions of this pre-July 15 work are mostly unspecific and generic ("review correspondence," "review IDR materials," "work on appeal and report") and make no specific reference to revisit tag F157. There is, in fact, nothing but Park Manor's unsubstantiated (and unsworn) assertion that these hours were spent investigating or litigating tag F157. We therefore deny reimbursement for these attorney hours. Even if we agreed that some pre-July 15 attorney's fees might be allocable to the compensable matter, we would not award them because Park

Manor has not proposed a basis or method for calculating the allocable amount.[4]

For the period from July 15 to October 15, 2002, Schedule 1 shows 26 attorney hours on days when the attorney may have been working on the July 22 summary judgment motion and supporting brief (July 15 to July 22), 46.4 attorney hours on days when work may have been performed on the September 12 submission (August 27 to September 10), and one-half hour spent reviewing the ALJ's summary judgment ruling. The claim for 26 hours is clearly excessive. The summary judgment argument that made Park Manor a prevailing party takes up barely two of 43 pages in the brief supporting the motion. The argument was not a complicated one: Park Manor cited a procedural fact – tag F157 was rescinded during IDR – and asserted that application of an instruction in CMS's State Operations Manual should result in dismissal of that tag. We find that no more than five attorney hours on this task is reasonable. We also find reasonable the one-half hour of time spent reviewing the ALJ's summary judgment ruling.

---

[4] Approximately 29 of these pre-July 15 hours, from June 10 to July 12, relate to a "motion to dismiss" that possibly was transformed into Park Manor's July 22 motion for summary judgment. As indicated, the billing descriptions for these hours do not mention revisit tag F157. They also suggest that some portion of the claimed hours was spent working on issues other than revisit tag F157 (see the entry for June 10 showing work on motion to dismiss "some deficiencies").

As for the attorney's work on the September 12 submission, we note that Schedule 1 shows 5.7 hours spent working on both the September 12 submission and reviewing a "new motion," presumably CMS's motion to require Park Manor to produce prior statements of witnesses. We deny reimbursement for all 5.7 hours because Park Manor has provided no basis for allocating these hours between the two tasks. In addition, we note that certain entries between August 27 and September 10 contain non-specific work descriptions, such as "legal research," "conferences with client," and "review materials from client." We find, nevertheless, that the September 12 submission contains substantial and reasonable legal arguments, and that these arguments were based in part on an investigation of state survey agency files. Under the circumstances, we find that 30 hours was a reasonable amount of attorney time to prepare the September 12 submission.

Finally, Schedule 1 shows 14.9 attorney hours spent on September 22 and 23 preparing a response to CMS's motion requesting production of witnesses' prior statements. We see nothing to indicate that this work aided Park Manor's effort to overturn tag F157 from the June revisit survey. The prior statements were from a state proceeding that addressed findings from the March survey. PM Ex. 54. We therefore deny reimbursement for these hours.

b. *Paralegal hours*

We allow only some of the paralegal hours claimed on Schedule 1. The problems with these hours are similar to the ones we identified with the attorney hours: some are for work prior to July 15; others have generic or non-specific billing descriptions; still others – the 3.5 hours billed by Caryl Hesslink to cite-check the summary judgment brief – are excessive because only a small portion of that brief contained material regarding revisit tag F157; finally, some hours are attributed to work on matters unrelated to revisit tag F157 (such as Park Manor's opposition to CMS's motion to produce prior statements of witnesses). We find that five of paralegal Hesslink's hours and 1.2 of paralegal Larson's hours are reasonable.

c. *Other fees and disbursements*

Schedule 1 requests $2,071.74 for expert witness fees and $702.08 for disbursements. The schedule contains no description of the services associated with these costs. Nor does it provide dates on which the services were performed. Equally significant, Park Manor has made no attempt to show that these costs are in fact related to its effort to overturn revisit tag F157. We therefore make no award for the claimed expert witness fees and disbursements.

We note that, with respect to the claimed disbursements, it is reasonable to assume that there are photocopying, postage, legal research, and other expenses attributable to Park Manor's litigation work

relating to revisit tag F157. Park Manor itemized these types of expenses in Exhibit J to its EAJA application. However, Park Manor has made no effort to link its current request with that itemization. Instead, it provides a raw figure ($2,071.74) without explaining how it was calculated. This does not satisfy Park Manor's burden of showing the reasonableness of its claimed costs.

d. *Summary for Schedule 1*

In sum, we find that the following costs from Schedule 1 are reasonable: (1) five attorney hours for work on the July 22 summary judgment motion; (2) 30 attorney hours for work on the September 12 submission; (3) one-half hour of attorney time to review the ALJ's summary judgment ruling; and (4) 6.2 hours of paralegal time. For these hours, we award fees of $4,866.[5]

2. Schedule 2

Schedule 2 shows several thousand dollars of fees and expenses that Park Manor claims were incurred for "defending against the allegations and remedies

[5] The amount is the total of the following: 35.5 total attorney hours at the statutory maximum rate of $125 per hour, or $4,438 (rounded), *plus* 5 paralegal hours (Hesslink) at $70 per hour, or $350, plus 1.2 paralegal hours (Larson) at $65 per hour, or $78. We note that CMS did not object to the hourly rates Park Manor charged for paralegal time.

in general, including the verification visit [revisit survey] allegations and remedies, *but for which the amount of attorney or paralegal time spent on any individual issue cannot now be specifically identified.*" Jan. 19 letter at 1-2 (emphasis added). Thus, for certain work, Schedule 2 shows the *total* fees and expenses incurred to perform that work even though some or most of it was devoted to issues unrelated to tag F157 or the June revisit findings. To compensate for this over-inclusiveness, Park Manor proposes an allocation formula based on the number of remedies at issue when the fees and expenses were incurred. There were, says Park Manor, three remedies in dispute when the fees and expenses in Schedule 2 were incurred: (1) a CMP based on the findings of the March survey; (2) a second CMP based on the findings of the June revisit survey; and (3) a DPNA based on the June revisit survey. CMS pursued the latter two remedies based on tag F157 from the June revisit survey. Thus, according to Park Manor, two-thirds of the remedies pursued by CMS between April 8 and October 16, 2002 were associated with the June revisit survey, and therefore two-thirds (66.7%) of the fees and expenses shown on Schedule 2 should be awarded.[6] Schedule 2 fees and expenses total

---

[6] In the alternative, Park Manor asserts that one-third of the Schedule 2 fees and expenses should be allowed on the theory that there were nine "issues" related to the June revisit survey (three "remedies" plus six deficiency tags) and that three of the nine issues (tag F157 plus the two remedies that were

(Continued on following page)

$36,624.34. Park Manor requests 66.7% of this total, or $24,428.51.

The EAJA contemplates that an award to a prevailing party will be based, in significant part, on the time and effort reasonably expended by counsel (and associated personnel) to achieve the favorable result. *See* 45 C.F.R. § 13.6(c) (indicating that a determination about the reasonableness of fees should be based on "time actually spent in the representation of the applicant" and "time reasonably spent in light of the difficulty or complexity of the issues"). Park Manor's proposed allocation formula does not purport to yield an estimate of actual time and effort; it simply allocates costs based on a factor – the number of disputed remedies – that has no apparent, significant, or necessary relationship to the level of time and effort expended in the litigation.

And, in fact, the formula does not yield a reasonable estimate of actual time and effort expended on the compensable matter, as the following example shows. Schedule 2 lists dozens of hours of attorney and paralegal work to prepare and submit a witness list, documentary exhibits, witness affidavits, and 60-plus page pre-hearing brief. Of the 55 documentary exhibits filed by Park Manor, only one – a transcript of the July 2001 IDR conference (PM Exhibit 34) – was related to revisit tag F157. Only four of the 21 witness affidavits

---

imposed after the June revisit survey) were ultimately pursued by CMS.

submitted by Park Manor contained testimony on revisit tag F157, and that testimony was a small percentage of the total testimony provided by these four witnesses. For example, Jenean Erickson, a nurse consultant, furnished a 23-page, 85-paragraph affidavit. About one and one-half pages of her affidavit address revisit tag F157. *See* PM Ex. 61, ¶¶ 76-80, Similarly, Paula Kock, Park Manor's nursing administrator, provided only two pages of testimony about tag F157 in a 36-page affidavit. PM Ex. 68, ¶¶ 74-78. Finally, the pre-hearing brief submitted by Park Manor contains only two pages of text regarding the June revisit survey and tag F157. Some of that text restates, nearly verbatim, part of the brief supporting Park Manor's motion for summary judgment, which was filed three weeks earlier. Under the circumstances, it is fair to say that a claim for two-thirds (or even one-third) of the total fees and expenses incurred to prepare and submit these pre-hearing materials is unreasonable.[7]

As indicated, Park Manor bears the burden to justify its fee and expense request. Its attempt to do so with respect to the Schedule 2 costs is, for the reasons given, entirely inadequate, and the failure to provide a reasonable allocation, has resulted in a patently excessive fee request. Accordingly, we will award less

---

[7] Schedule 2 reports expert witness expenses of $1,481.53 and disbursements of $2,731.42. Like Schedule 1, Schedule 2 contains no description of the services purchased and does not show how the amount of disbursements was calculated.

than what might otherwise be considered reasonable. *Cf. Environmental Defense Fund, Inc. v. Reilly*, 1 F.3d 1254, 1258 (D.C. Cir. 1993) (indicating that the court had the discretion to deny an "outrageously unreasonable" fee request in its entirety, and that "less egregious" overbilling may be sanctioned by awarding an amount chat is less than what a reasonable fee would be). We award $1,000 in fees for the work described in Schedule 2.

3. Schedules 3 and 4

The bulk of the claimed fees and expenses is for work on the EAJA litigation. Schedule 3 shows fees and expenses incurred by Park Manor in the EAJA litigation prior to the issuance of DAB No. 2005. Its claim under Schedule 3 is based on application of the allocation formula that was applied to the Schedule 2 costs. Schedule 4 shows fees and expenses incurred by Park Manor in responding to DAB No. 2005.

Although an EAJA award may include an amount for work performed in the fee litigation, that amount must be commensurate with the success Park Manor achieved in that litigation. *See Commissioner I.N.S. v. Jean*, 496 U.S. 154, 163 n.10 (1990) ("fees for fee litigation should be excluded to the extent that the applicant ultimately fails to prevail in such litigation"). Park Manor was largely unsuccessful in the fee litigation. We found that CMS's position with respect to six of the seven deficiencies actually litigated in the merits proceeding was substantially justified.

DAB No. 2005, at 26-62. We also rejected Park Manor's contention that CMS lacked substantial justification for its May and July 2001 decisions to impose remedies. *Id.* at 21-26. Finally, we rejected Park Manor's claim for an award pursuant to 5 U.S.C. § 504(a)(4). *Id.* at 70-73. Park Manor's success in the fee litigation relates to a single deficiency finding, whose merits were addressed during a three-month period in a proceeding that spanned almost three years. This deficiency finding, and the circumstances that led to the favorable summary judgment ruling on revisit tag F157, are discussed only briefly in several dozen pages of Park Manor's written EAJA arguments. Nevertheless, Park Manor calculated its claimed award in Schedule 3 based on a flawed allocation formula that takes no account of the success achieved in the fee litigation. Under the circumstances, a request for $65,000 in fee litigation expenses under Schedule 3 is clearly exorbitant and unreasonable, and Park Manor should have known it was. For this reason, we again award less than what might be reasonable. The award for Schedule 3 is $1,000.

Finally, we note that the revised fee request submitted by Park Manor assisted us only negligibly in identifying and calculating the costs properly allocable to the only compensable matter. In DAB No. 2005, we gave Park Manor an opportunity to provide a reasonable method of allocating its previously documented costs. It failed to do so. For these reasons, we will not require CMS to pay for the fees and expenses shown in Schedule 4.

To summarize, we award $4,866 in fees from Schedule 1, $1,000 in fees from Schedule 2, and $1,000 in fees from Schedules 3 and 4.[8] The total EAJA award is therefore $6,866.

Conclusion

Park Manor is entitled to an award of $6,866 under the EAJA. The Board's decision in DAB No. 2005 and this addendum together constitute the final decision of the Secretary of Health and Human Services on Park Manor's July 14, 2004 Application for Attorneys' Fees, Costs and Expenses.

/s/ Cecilia Sparks Ford
Cecilia Sparks Ford

/s/ Donald F. Garrett
Donald F. Garrett

/s/ Judita A. Ballard
Judith A. Ballard
Presiding Board Member

[8] In addition to the fees and expenses shown in Schedules 1-4, Park Manor asks that we award the fees and expenses it incurred to respond to CMS's motion to reconsider our first decision in this case, DAB No. 1926. We deny this request because DAB No. 1935, and the ensuing motion to reconsider, dealt with a deficiency from the March survey. The Board found that CMS's pursuit of a remedy based on the March survey was substantially justified. DAB No. 2005, at 27-34.

2004 WL 1764725 (H.H.S.)

Department of Health and Human Services
(H.H.S.)

Departmental Appeals Board

Appellate Division

IN THE CASE OF: PARK MANOR NURSING HOME, PETITIONER

v.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Civil Remedies CR1090
App. Div. Dkt. No. A-04-31
Decision No. 1926

June 17, 2004

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner, Park Manor Nursing Home (Park Manor), appealed a March 31, 2003 decision by Administrative Law Judge (ALJ) Steven T. Kessel. *Park Manor Nursing Home*, DAB CR1090 (2003) (ALJ Decision). The ALJ Decision affirmed a $150 per day civil money penalty (CMP) imposed on Park Manor by the Centers for Medicare & Medicaid Services (CMS) for the period March 22 through June 10, 2001. In affirming the CMP, the ALJ determined that Park Manor was not in substantial compliance with 42 C.F.R. § 483.10(b)(11), which requires a skilled nursing facility to consult a resident's physician when there is a "significant change" in a resident's physical,

mental, or psychosocial status. The ALJ found that Park Manor had failed to consult with a physician about signs and symptoms that were, according to the ALJ, evidence of "significant changes" in Resident 20's status.

For the reasons explained below, we conclude, among other things, that 1) both the ALJ and the surveyor on whose testimony he relied misapplied the regulations in evaluating whether the resident's signs and symptoms occurring after Park Manor had consulted with the resident's physician were significant changes requiring further physician consultation; 2) the ALJ ignored undisputed evidence about changes that had occurred in the resident's status *before* Park Manor last consulted with the physician and about the resident's wishes for comfort measures only; 3) under the particular circumstances here, Park Manor reasonably determined it was not required to consult the physician again; and 4) in any event, CMS did not make a *prima facie* showing that Park Manor's failure to consult the physician about the alleged changes created the potential for more than minimal harm. Accordingly, we reverse the ALJ's determination that Park Manor was not in substantial compliance with section 483.10(b)(11) and set aside the $150 per day CMP.

Regulatory Background

Park Manor is a Wisconsin skilled nursing facility that participates in the Medicare program. Medicare's

participation requirements for skilled nursing and other long-term care facilities are set forth in 42 C.F.R. Part 483, Subpart B.

Compliance with Medicare participation requirements is verified through surveys performed by state agencies under contract with CMS. The survey agency reports any "deficiencies" on a standard form called a "Statement of Deficiencies" (SOD). *See* 42 C.F.R. § 488.325(a); CMS State Operations Manual (SOM), Appendix (App.) P, sec. IV. A "deficiency" is a failure to a meet a participation requirement in 42 C.F.R. Part 483. 42 C.F.R. § 488.301. Deficiency findings are organized in the SOD under alpha-numeric "tags," with each tag corresponding to a regulatory requirement in Part 483 of the regulations. *See* SOM, App. P, sec. IV.

A survey agency's findings include a determination about the "seriousness" of each deficiency. *See* 42 C.F.R. § 488.404; SOM § 7400(E). "Seriousness" is largely a function of the deficiency's scope (isolated, pattern, or widespread) and of the harm that the deficiency has caused or has the potential to cause. *See* 42 C.F.R. § 488.404(b). Seriousness is denoted in the SOD by a letter (A-L) that reflects a particular combination of scope and level of harm. *See* SOM § 7400(E). The most serious deficiencies are ones that result in "actual harm" or that place residents in "immediate jeopardy." *Id.*

A facility becomes subject to remedial action when it is not in "substantial compliance" with one or

more participation requirements. *See* 42 C.F.R. § 488.400. A facility is not in substantial compliance if it has a deficiency that creates at least the "potential for more than minimal harm" to one or more residents. 42 C.F.R. §§ 488.301. CMS may impose a CMP for the days on which the facility is in a state of noncompliance. 42 C.F.R. §§ 488.404, 488.406 and 488.408. ("Noncompliance" is defined in 42 C.F.R. § 488.301 of the regulations to mean "any deficiency that causes a facility to not be in substantial compliance.")

Case Background

On March 22, 2001, the Wisconsin Department of Health and Family Services (WDHFS) completed a standard survey (the "March 2001 survey") of Park Manor. *See* CMS Ex. 3. The March 2001 survey found several deficiencies, which WDHFS described in Statement of Deficiencies (SOD) number 618331. CMS Ex. 1. After revisit surveys, informal dispute resolution proceedings, and preliminary proceedings before the ALJ, the issues in dispute were substantially narrowed. The ALJ ruled that only five alleged deficiencies – described under tags F157, F279, F309, F332, and F496 in SOD number 620504 (CMS Ex. 4) – were at issue before him at the hearing. *See* Ruling on Petitioner's Motion for Summary Disposition (dated October 8, 2002), at 7.

The parties presented testimony and evidence regarding these five deficiencies. The ALJ, however,

limited his factual and legal findings to CMS's allegations under tag F157, which were that Park Manor had failed to consult with a physician about significant changes in Resident 20's status.

Resident 20 was 91 years old, and his primary diagnosis was dementia. CMS Ex. 12, at 3, 12. His care plan indicated that he was a "no code" resident, meaning that he did not want aggressive measures (such as CPR) to prolong his life, and that he was to be provided "comfort measures" at the end of life. *See* Park Manor Ex. 1, at 3; Park Manor Ex. 68, ¶ 14. Nursing progress notes submitted by CMS show that on Friday, March 2, 2001, Resident 20 developed an elevated temperature and other symptoms of a urinary tract infection (UTI). CMS Ex. 13, at 1. A nurse called and left a message with the physician about the symptoms. *Id.* At approximately 5:26 p.m. on March 2, the physician phoned back with new orders for testing and treatment to address the suspected infection. *Id.* Thereafter, a nurse spoke with Rosemary Plant, Resident 20's guardian, in order to obtain informed consent for the testing and treatment (a urinalysis and the administration of an antibiotic). *Id.*; Park Manor Ex. 72, ¶ 21. At 9:46 p.m., a nurse spoke to the physician a second time to update him on Resident 20's status. CMS Ex. 13, at 1. The nurse also left a message for Plant to update her on Resident 20's condition. *Id.* Plant visited the facility on Sunday,

March 4.[1] Park Manor did not contact the physician again until 9:30 a.m. on Monday, March 5. CMS asserted, however, that Park Manor was required to, and did not, consult immediately with the physician concerning significant changes in Resident 20's condition on Saturday, March 3, and Sunday, March 4, 2001. Resident 20 died early on March 6, 2001. CMS Ex. 4, at 2.

CMS presented testimony regarding Resident 20 only from the nurse surveyor who had drafted the deficiency finding, Wanda Hardges. CMS Ex. 54. Park Manor presented testimony from three witnesses who were personally familiar with Resident 20: Karen Haegerl (the day shift nurse on March 3 and 4); Paula Kock (Park Manor's administrator); and Rosemary Plant, Resident 20's niece and legal guardian, who had 39 years of nursing experience. *See* Park Manor Exs. 63, 68, and 72.[2]

---

[1] The SOD alleged that, although Park Manor had consulted with a physician at 5:26 p.m. on Friday, March 2, 2001, Park Manor had not notified Resident 20's legal guardian, nor consulted with the physician again until 9:30 a.m. on the morning of Monday, March 5, 2001. *See* CMS Ex. 4, at 2. Before the ALJ, CMS did not dispute Park Manor's assertions and evidence that it had also consulted with the physician later on Friday evening (at 9:46 p.m.) and had also reported Resident 20's condition to the guardian, and that the legal guardian had visited the facility in the afternoon on Sunday, March 4.

[2] The witnesses gave their direct testimony in writing and were cross-examined at the hearing.

Rosemary Plan and Paula Kock testified that Resident 20's physical and mental condition had been declining since at least January 2001. Park Manor Exs. 68, ¶ 12 and 72, ¶¶ 18-19.

Plant testified that in her conversation with the nursing staff on March 2, the nurse told her "that the news [about her uncle] was not good" and that he had eaten poorly for the past two days. Park Manor Ex. 72, ¶ 21. Plant testified that the message left for her by the nursing staff at around 9:45 p.m. on March 2 was that her uncle was continuing to deteriorate and that if she wanted anything more than comfort measures she should call back. *Id.*, ¶ 22. Plant also testified that she did not call Park Manor back "because I did not want anything more than comfort measures." *Id.*

Park Manor also submitted evidence that Ms. Plant had been involved in developing a written care plan for Resident 20 that provided for a "no code" order (also referred to by the ALJ as a "do not resuscitate" or "DNR" order), and that also specified that the resident was to be kept comfortable and provided only "comfort measures." Park Manor Ex. 1, at 3; Park Manor Ex. 72, ¶¶ 10-15, 17. The plan was based on the resident's wishes, as expressed during his 40-year relationship with Ms. Plant; she had repeatedly discussed this with the facility and how he would not have wanted any aggressive interventions to merely prolong his life. Park Manor Ex. 72, ¶ 17. She had agreed to the treatment for the UTI because she knew a UTI could cause discomfort, but would not

have agreed to any intervention such as giving him oxygen or intravenous feeding, unless clearly needed to keep him comfortable. *Id.*, ¶ 27; CMS Ex. 66, at 19, 22. She further testified that she viewed the UTI and other symptoms of which she was informed on Friday evening (including decreased appetite) as a manifestation of his overall decline (part of the final stages of his dementia). Park Manor Ex. 72, ¶ 29. She also testified that, when she visited him on March 4 (as she did every Sunday and Tuesday), he was resting peacefully and "slowly slipping away." *Id.*, ¶ 23. She testified that she felt that he received excellent care and was kept comfortable and allowed to die with dignity and that the facility had been diligent in keeping her informed about his status. *Id.*, ¶¶ 27-28, 34. She had informed the facility that she was a nurse. *Id.*, ¶ 11.

Park Manor also submitted evidence that on Sunday, March 4, the resident had seemed to be responding to the treatment for the UTI and that, when a new nurse came onto the day shift on March 5 and evaluated all of the changes that had occurred since Sunday afternoon, she did contact the physician's office and left him a message regarding the resident's continuing deterioration. *See* Park Manor Ex. 68, ¶ 21; CMS Ex. 13, at 2. The physician (who also was familiar with the resident's wishes) did not order any new treatment. *See* CMS Ex. 13, at 2.

Based on the resident's medical records (primarily his diagnoses and his resident assessment from October 2000) and the testimony of Nurse Hardges,

CMS identified a number of signs and symptoms reported on March 3 or 4 that it contended were "significant changes" that triggered Park Manor's obligation to consult with Resident 20's physician again. *See* CMS Post-Hearing Brief (PHB) at 2-9. These changes included: (1) a reduction in Resident 20's oxygen saturation level on March 3; (2) his decreased ability to ambulate on March 3 and March 4; (3) his "unresponsiveness" on March 4 (a condition reported by Rosemary Plant); and (4) mottling of the lower extremities on March 4. *Id.*

ALJ Decision

The ALJ found that a reduction in Resident 20's oxygen saturation level on March 3, coupled with his other vital signs on that day, did not necessitate immediate physician consultation. ALJ Decision at 5-6. However, the ALJ found that Resident 20's diminished ability to ambulate, unresponsiveness, and mottling were "significant changes" that Park Manor did not immediately report to the physician. *Id.* at 6. The ALJ found that neither the care plan nor the legal guardian directed the facility not to contact the physician. *Id.* at 7. The ALJ also found that Park Manor's inaction created the potential for more than minimal harm. *Id.* at 9. Based on these findings, the ALJ concluded that Park Manor was not in substantial compliance with 42 C.F.R. § 483.10(b)(11). The ALJ found it unnecessary to address the other four alleged deficiencies because the violation of section 483.10(b)(11) was, in his estimation, sufficient to

justify a $150 per day CMP. *Id.* at 9-11. Finally, the ALJ found that Park Manor was in a state of non-compliance from March 22 through June 10, 2001, and that CMS was authorized to collect a CMP for each day of that period. *Id.* at 11-12.

In reaching his findings, the ALJ did not state that he found Park Manor's witnesses not to be credible, but indicated merely that he was not persuaded by them. *See* ALJ Decision at 8.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed issue of fact is whether the ALJ decision as to that fact is supported by substantial evidence on the record as a whole. *See* Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (at http://www.hhs.gov/dab/guidelines/); *South Valley Health Care Center*, DAB No. 1691 (1999), *aff'd, South Valley Health Care Center v. HCFA*, 223 F.3d 1221 (10th Cir. 2000).

The Parties' Contentions

In its request for review (submitted on December 9, 2003, after receipt of several extensions), Park Manor contended that the ALJ's finding that it failed to comply with section 483.10(b)(11) is not supported

by substantial evidence, and that it met its burden of demonstrating that it was in substantial compliance with that regulation. Request for Review (RR) at 10, 19. Park Manor emphasized that it had introduced uncontradicted expert opinions from qualified nurses that Resident 20 did not experience a significant change in status on March 3 and 4, and that nursing standards of practice did not require immediate physician notification when a guardian does not want further treatment. *Id.* at 9-21. Park Manor faulted the ALJ for finding the "unresponsiveness" reported by Ms. Plant to be a significant change since CMS had originally relied only on a notation regarding the resident's lethargy (which Park Manor had shown was not a change). *Id.* at 25-30. Park Manor also contended that it was not required to consult with the physician under the circumstances because Resident 20's guardian had made it clear that she wanted no further treatment during the weekend in question, only "comfort measures," which were in fact provided. *Id.* at 22-25. Citing 42 C.F.R. §§ 483.10(a)(3) and 483.10(b)(4), Park Manor contended that it was legally and morally bound to honor the guardian's wishes not to take further action and to allow Resident 20 to die with dignity. *Id.* at 23-24. In addition, Park Manor contended that CMS had failed to carry its burden of proving that the alleged noncompliance with section 483.10(b)(11) created the potential for more than minimal harm. *Id.* at 30-32.

CMS responded that the ALJ's finding that the resident's need for assistance in ambulation, his

unresponsiveness, and the mottling were significant changes was supported by substantial evidence and that the ALJ's conclusion that Park Manor was not in substantial compliance with section 483.10(b)(11) is consistent with applicable case law. Response Brief at 10-22, 24-25. CMS relied primarily on Surveyor Hardges' opinion and on selected parts of the other witnesses' testimony. *Id.* at 13-17. CMS also said that lethargy and unresponsiveness were essentially the same, and that Park Manor had notice that this was at issue. *Id.* at 17-18. CMS also contended that substantial evidence supported the ALJ's findings regarding Resident 20's plan of care and the guardian's wishes. *Id.* at 22-24.

Discussion

The regulation at 42 C.F.R. § 483.10 is titled "Resident rights." In the case of a resident "judged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf." 42 C.F.R. § 483.10(a)(3). Subsection (b)(11), on notification of changes, provides that a facility must consult with the resident's physician when there is a "significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)." 42 C.F.R. § 483.10(b)(11).

The preamble to the final rule implementing this provision responded to a request that CMS define the term "significant change." The preamble explained that the term would be defined as a "deterioration in health, mental, or psychosocial status in either life-threatening conditions (for example, heart attack, stroke) or clinical complications (for example, development of a stage II pressure sore, onset or recurrent periods of delirium)." 56 Fed. Reg. 48826, 48833 (Sept. 26, 1991) (emphasis added).[3]

The preamble also stated:

> We recognize that *judgment must be used* in determining whether a change in the resident's condition is significant enough to warrant notification, and accept the comment that only those injuries *which have the potential for needing physician intervention* must be reported to the physician.

Id. (emphasis added).

A resident also has the right to refuse treatment and to formulate an advance directive. 42 C.F.R. §§ 483.10(b)(4) and (b)(8). An advance directive is "a written instruction, such as a living will or durable power of attorney for health care, recognized under

---

[3] The ALJ referred to a deterioration in status in "life-threatening conditions" or "clinical complications" as *examples* of changes that would be considered significant. *See* ALJ Decision at 4. This is inconsistent with the regulatory wording, which uses "i.e." (meaning "that is") rather than "e.g." (meaning "for example") and with the preamble explanation.

State law . . . relating to the provision of health care when the individual is incapacitated." 42 C.F.R. §§ 489.100 and 483.10(b)(8).

Neither the surveyor's testimony on which the ALJ relied nor CMS guidance directly addresses how the regulatory definition of a "significant change" as a deterioration in status in life-threatening conditions or clinical complications applies in the context of an individual who is dying, but has requested comfort measures only. *See* State Operations Manual, App. PP (Surveyor Guidelines for tag F157). Indeed, the surveyor's affidavit states that a significant change is one that "could affect the physical or mental well-being of the resident," without indicating how this articulation comports with the regulatory definition. CMS Ex. 54, ¶ 12.

Based on the language of the regulation, its context, and its history, we conclude that both the ALJ and the surveyor on whose testimony he relied erred in evaluating whether the resident's signs and symptoms were significant changes requiring further physician consultation. Not only is it not clear that they were applying the regulatory definition, but, more important, neither gave appropriate consideration to the undisputed evidence about changes that had occurred in the resident's status *before* Park Manor last consulted with the physician or to the undisputed evidence about the resident's wishes for comfort measures only. Specifically, we conclude that –

• CMS and the ALJ erroneously treated the resident's status as of March 2 as though his only physical problems were the UTI, a hearing loss, and edema, ignoring evidence in the record that the caregivers and the resident's legal guardian viewed the entirety of his signs and symptoms (including his profound dementia) as evidencing that this 91-year old resident was likely in the final stages of an overall physical and mental decline, including increasing periods of lethargy which the facility had tried to address through seeking changes in his medications, without success. Moreover, the resident's records show that some symptoms (such as congestion and lethargy) on which CMS relied as showing change *following* notification of the physician of the UTI symptoms had already appeared before the last call to the physician Friday evening, giving him an update on the resident's condition. *See* CMS Ex. 13. Yet, the physician did not order anything more at that time than an antibiotic for the UTI and a urinalysis.

• The evidence in the resident's records as a whole, as well as the testimony of individuals familiar with the resident, also show that his need for assistance with ambulation and his lethargy (unresponsiveness) were consistent with his prior decline and with his having a UTI – a clinical complication for which it is undisputed that the physician was consulted on March 2. *See* Park Manor Ex. 68, ¶¶ 12, 20; Park Manor Ex. 72, ¶¶ 18-19.

• The ALJ correctly recognized that it would be a physician's judgment what treatment might be needed for a particular complex of signs and symptoms constituting a significant change in a resident's physical status. But, as CMS acknowledged in the preamble to the regulation, determining *whether* a change is significant with respect to a particular resident involves a nursing judgment.

• The ALJ appeared to conclude that the resident's end of life wishes were expressed only in the "no code" order, and, therefore, the physician should have been consulted to determine whether the changes that occurred on Sunday in fact signified a condition, such as cardiac arrest, for which the only treatment would have been resuscitation. The uncontroverted evidence submitted by Park Manor establishes, however, that the legal guardian (who could exercise the resident's rights on his behalf) had been involved in developing the written care plan that specified that he was to receive comfort measures only.

• While Park Manor acknowledged that the "mottling" which the resident evidenced Sunday evening (some time between 4 p.m. and 10:23 p.m.) would have been a significant change for a resident who was "full code," Park Manor exercised reasonable nursing judgment that it was not required to notify the physician at that time since the resident did not appear to be suffering any

pain or discomfort and since the legal guardian had clearly communicated that she would refuse on his behalf any treatment meant merely to prolong the resident's life. While the ALJ correctly found that the legal guardian did not specifically direct the facility not to notify the physician of any additional changes, she did testify that she had had many previous discussions with them on end of life issues, that she did not want them to notify the physician, and that she would only have wanted treatment if needed for pain or discomfort. *See* Park Manor Ex. 72, ¶¶ 17, 23-24. The right to notification is a resident right that may be exercised through a legal guardian. Here, the legal guardian was also a nurse. She was aware of his status as dying, but requested no change even after visiting the resident Sunday afternoon.

• Requirements for consultation with a physician in circumstances of injury or need for change in treatment refer to the need for medical intervention. 42 C.F.R. § 483.10(b)(11)(A-C). Thus, Park Manor could reasonably think that, if no medical intervention was needed for the resident's comfort and if the guardian would have rejected measures such as administering oxygen, consulting with the physician would have been a useless exercise and was not required.

• When the physician (who also was familiar with the resident's wishes) was consulted

early in the morning on Monday, March 5, he did not order any new treatment.

- The outcome for this resident was what the resident wished. CMS pointed to no evidence that the resident did not receive comfort care, as desired, nor did it suggest any potential medical interventions other than oxygen and intravenous feeding, both of which the guardian had said she would refuse. *See* Park Manor Ex. 72, ¶ 27.

- Even if the "mottling" on Sunday evening were considered a significant change requiring immediate notification, the less than 12-hour time lapse between the facility noting this symptom and notifying the physician did not have the consequences of the delays in other cases cited by CMS. CMS failed to make a *prima facie* case here that there was a potential for more than minimal harm since it did not show that the resident was in any pain or discomfort during this period or that the physician would have ordered any additional intervention if contacted sooner.

Accordingly, we reverse the ALJ's finding that Park Manor was not in substantial compliance with 42 C.F.R. § 483.10(b)(11).

Having reversed the ALJ's finding of noncompliance, we must consider whether it is appropriate to set aside the CMP or to remand the case to the ALJ for further proceedings. As indicated, the ALJ concluded that $150 per day was a reasonable CMP for the one deficiency he addressed. Park Manor argued

in its request for review that we should reverse the ALJ's finding of noncompliance and set aside the decision in its entirety. *See* RR at 9. In response, CMS did not state that, if the finding of noncompliance were reversed, the case should be remanded to the ALJ for findings on the other four alleged deficiencies for which the parties submitted evidence. Each of those alleged deficiencies was assigned a lower level of seriousness (levels D or E). None was at a level of seriousness that would have required that a CMP be imposed. In addition, we note that these other alleged deficiencies represent only a small fraction of the survey agency's original deficiency findings, many of which were overturned, modified, or effectively withdrawn by CMS during IDR and the ALJ proceedings.[4]

---

[4] Following IDR, the survey agency withdrew a finding of immediate jeopardy (and the associated penalty), amended other deficiency findings, and reissued its SOD. *See* CMS Exs. 1, 4, 7, 61. The reissued SOD (number 620504) contained 15 deficiency findings but CMS elected to present evidence on only five. *See* CMS Prehearing Brief at 3-22. CMS accordingly stipulated to a reduction in the non-immediate jeopardy level CMP from $250 to $150 per day for the period prior to the June 2001 revisit survey. *Id.* at 3, n.3. The June 2001 revisit yielded additional deficiency findings (*see* CMS Ex. 6), but two of those were withdrawn during IDR, and CMS presented evidence on only one of the remaining findings. *See* CMS Exs. 7, 60-61; Park Manor Ex. 34; CMS Prehearing Brief, at 3, n.3. In a ruling on a motion for summary judgment, the ALJ found that this one deficiency finding had in fact been rescinded by the survey agency as the result of IDR, and that CMS lacked a basis for imposing any remedies after June 10, 2001. *See* Ruling on Petitioner's Motion for Summary Disposition (dated October 8, 2002) at 3.

Based on these findings, CMS had imposed a denial of payment for new admissions that was in effect from July 15 to July 23, 2001.

Given these circumstances, we do not think that further proceedings would serve the remedial purpose of the regulations, which is to provide the facility with an incentive to come into and remain in compliance. *See Fairfax Nursing Home, Inc.*, DAB No. 1794, at 18-19 (2001), *aff'd, Fairfax Nursing Home v. Dep't of Health & Human Servs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111 (2003). Accordingly, we have determined here that reversal of the CMP is more appropriate than further proceedings to address the remaining deficiencies.

Conclusion

For the reasons above, we reverse the ALJ's finding that Park Manor was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) from March 22, 2001 through June 10, 2001 and set aside the CMP imposed by CMS for that period.

Cecilia Sparks Ford

Donald F. Garrett

Judith A. Ballard
Presiding Board Member

5 U.S.C. § 504

§ 504. Costs and fees of parties

(a)(1) An agency that conducts an adversary adjudication shall award, to a prevailing party other than the United States, fees and other expenses incurred by that party in connection with that proceeding, unless the adjudicative officer of the agency finds that the position of the agency was substantially justified or that special circumstances make an award unjust. Whether or not the position of the agency was substantially justified shall be determined on the basis of the administrative record, as a whole, which is made in the adversary adjudication for which fees and other expenses are sought.

(2) A party seeking an award of fees and other expenses shall, within thirty days of a final disposition in the adversary adjudication, submit to the agency an application which shows that the party is a prevailing party and is eligible to receive an award under this section, and the amount sought, including an itemized statement from any attorney, agent, or expert witness representing or appearing in behalf of the party stating the actual time expended and the rate at which fees and other expenses were computed. The party shall also allege that the position of the agency was not substantially justified. When the United States appeals the underlying merits of an adversary adjudication, no decision on an application for fees and other expenses in connection with that adversary adjudication shall be made under this section until a final and unreviewable decision is

rendered by the court on the appeal or until the underlying merits of the case have been finally determined pursuant to the appeal.

(3) The adjudicative officer of the agency may reduce the amount to be awarded, or deny an award, to the extent that the party during the course of the proceedings engaged in conduct which unduly and unreasonably protracted the final resolution of the matter in controversy. The decision of the adjudicative officer of the agency under this section shall be made a part of the record containing the final decision of the agency and shall include written findings and conclusions and the reason or basis therefor. The decision of the agency on the application for fees and other expenses shall be the final administrative decision under this section.

(4) If, in an adversary adjudication arising from an agency action to enforce a party's compliance with a statutory or regulatory requirement, the demand by the agency is substantially in excess of the decision of the adjudicative officer and is unreasonable when compared with such decision, under the facts and circumstances of the case, the adjudicative officer shall award to the party the fees and other expenses related to defending against the excessive demand, unless the party has committed a willful violation of law or otherwise acted in bad faith, or special circumstances make an award unjust. Fees and expenses awarded under this paragraph shall be paid only as a consequence of appropriations provided in advance.

(b)(1) For the purposes of this section –

(A) "fees and other expenses" includes the reasonable expenses of expert witnesses, the reasonable cost of any study, analysis, engineering report, test, or project which is found by the agency to be necessary for the preparation of the party's case, and reasonable attorney or agent fees (The amount of fees awarded under this section shall be based upon prevailing market rates for the kind and quality of the services furnished, except that (i) no expert witness shall be compensated at a rate in excess of the highest rate of compensation for expert witnesses paid by the agency involved, and (ii) attorney or agent fees shall not be awarded in excess of $125 per hour unless the agency determines by regulation that an increase in the cost of living or a special factor, such as the limited availability of qualified attorneys or agents for the proceedings involved, justifies a higher fee.);

(B) "party" means a party, as defined in section 551(3) of this title, who is (i) an individual whose net worth did not exceed $2,000,000 at the time the adversary adjudication was initiated, or (ii) any owner of an unincorporated business, or any partnership, corporation, association, unit of local government, or organization, the net worth of which did not exceed $7,000,000 at the time the adversary adjudication was initiated, and which had not more than 500 employees at the time the adversary adjudication was initiated; except that an organization described in section 501(c)(3) of the Internal Revenue Code of 1986

(26 U.S.C. 501(c)(3)) exempt from taxation under section 501(a) of such Code, or a cooperative association as defined in section 15(a) of the Agricultural Marketing Act (12 U.S.C. 1141j(a)), may be a party regardless of the net worth of such organization or cooperative association or for purposes of subsection (a)(4), a small entity as defined in section 601;

(C) "adversary adjudication" means (i) an adjudication under section 554 of this title in which the position of the United States is represented by counsel or otherwise, but excludes an adjudication for the purpose of establishing or fixing a rate or for the purpose of granting or renewing a license, (ii) any appeal of a decision made pursuant to section 6 of the Contract Disputes Act of 1978 (41 U.S.C. 605) before an agency board of contract appeals as provided in section 8 of that Act (41 U.S.C. 607), (iii) any hearing conducted under chapter 38 of title 31, and (iv) the Religious Freedom Restoration Act of 1993;

(D) "adjudicative officer" means the deciding official, without regard to whether the official is designated as an administrative law judge, a hearing officer or examiner, or otherwise, who presided at the adversary adjudication;

(E) "position of the agency" means, in addition to the position taken by the agency in the adversary adjudication, the action or failure to act by the agency upon which the adversary adjudication is based; except that fees and other expenses may not be awarded to a party for any portion of the adversary

adjudication in which the party has unreasonably protracted the proceedings; and

(F) "demand" means the express demand of the agency which led to the adversary adjudication, but does not include a recitation by the agency of the maximum statutory penalty (i) in the administrative complaint, or (ii) elsewhere when accompanied by an express demand for a lesser amount.

(2) Except as otherwise provided in paragraph (1), the definitions provided in section 551 of this title apply to this section.

(c)(1) After consultation with the Chairman of the Administrative Conference of the United States, each agency shall by rule establish uniform procedures for the submission and consideration of applications for an award of fees and other expenses. If a court reviews the underlying decision of the adversary adjudication, an award for fees and other expenses may be made only pursuant to section 2412(d)(3) of title 28, United States Code.

(2) If a party other than the United States is dissatisfied with a determination of fees and other expenses made under subsection (a), that party may, within 30 days after the determination is made, appeal the determination to the court of the United States having jurisdiction to review the merits of the underlying decision of the agency adversary adjudication. The court's determination on any appeal heard under this paragraph shall be based solely on the factual record made before the agency. The court may

modify the determination of fees and other expenses only if the court finds that the failure to make an award of fees and other expenses, or the calculation of the amount of the award, was unsupported by substantial evidence.

(d) Fees and other expenses awarded under this subsection shall be paid by any agency over which the party prevails from any funds made available to the agency by appropriation or otherwise.

(e) The Chairman of the Administrative Conference of the United States, after consultation with the Chief Counsel for Advocacy of the Small Business Administration, shall report annually to the Congress on the amount of fees and other expenses awarded during the preceding fiscal year pursuant to this section. The report shall describe the number, nature, and amount of the awards, the claims involved in the controversy, and any other relevant information which may aid the Congress in evaluating the scope and impact of such awards. Each agency shall provide the Chairman with such information as is necessary for the Chairman to comply with the requirements of this subsection.

(f) No award may be made under this section for costs, fees, or other expenses which may be awarded under section 7430 of the Internal Revenue Code of 1986.

45 C.F.R. § 13.1 Purpose of these rules.

These rules implement section 203 of the Equal Access to Justice Act, 5 U.S.C. 504 and 504 note, for the Department of Health and Human Services. They describe the circumstances under which the Department may award attorney fees and certain other expenses to eligible individuals and entities who prevail over the Department in certain administrative proceedings (called "adversary adjudications"). The Department may reimburse parties for expenses incurred in adversary adjudications if the party prevails in the proceeding and if the Department's position in the proceeding was not substantially justified or if the action is one to enforce compliance with a statutory or regulatory requirement and the Department's demand is substantially in excess of the ultimate decision and is unreasonable when compared with that decision. They also describe what proceedings constitute adversary adjudications covered by the Act, what types of persons and entities may be eligible for an award, and what procedures and standards the Department will use to make a determination as to whether a party may receive an award.

---

45 C.F.R. § 13.2 When these rules apply.

These rules apply to adversary adjudications before the Department.

---

45 C.F.R. § 13.3 Proceedings covered.

(a) These rules apply only to adversary adjudications. For the purpose of these rules, only an adjudication required to be under 5 U.S.C. 554, in which the position of the Department or one of its components is represented by an attorney or other representative ("the agency's litigating party") who enters an appearance and participates in the proceeding, constitutes an adversary adjudication. These rules do not apply to proceedings for the purpose of establishing or fixing a rate or for the purpose of granting, denying, or renewing a license.

(b) If the agency's litigating party enters an appearance, Department proceedings listed in Appendix A to this part are covered by these rules. Also covered are any other proceedings under statutes that incorporate by reference the procedures of sections 1128(f), 1128A(c)(2), or 1842(j)(2) of the Social Security Act, 42 U.S.C. 1320a-7(f), 1320a-7a(c)(2), or 1395u(j)(2). If a proceeding is not covered under either of the two previous sentences, a party may file a fee application as otherwise required by this part and may argue that the Act covers the proceeding. Any coverage issue shall be determined by the adjudicative officer and, if necessary, by the appellate authority on review.

(c) If a proceeding is covered by these rules, but also involves issues excluded under paragraph (a) of this

section from the coverage of these rules, reimbursement is available only for fees and expenses resulting from covered issues.

---

45 C.F.R. § 13.4 Eligibility of applicants.

(a) To be eligible for an award of attorney fees and other expenses under these regulations, the applicant must be a party, as defined in 5 U.S.C. 551(3), to the adversary adjudication for which it seeks an award. An applicant must show that it meets all conditions of eligibility set out in this subpart and in subpart B.

(b) The categories of eligible applicants are as follows:

(1) Charitable or other tax-exempt organizations described in section 501(c)(3) of the Internal Revenue Code (26 U.S.C. 501(c)(3)) with not more than 500 employees;

(2) Cooperative associations as defined in section 15(a) of the Agricultural Marketing Act (12 U.S.C. 1141j(a)) with not more than 500 employees;

(3) Individuals with a net worth of not more than $2 million;

(4) Sole owners of unincorporated businesses if the owner has a net worth of not more than $7 million, including both personal and business interests, and if the business has not more than 500 employees;

(5) All other partnerships, corporations, associations, local governmental units, and public and private organizations with a net worth of not more than $7 million and with not more than 500 employees; and

(6) Where an award is sought on the basis stated in § 13.5(c) of this part, small entities as defined in 5 U.S.C. 601.

(c) For the purpose of determining eligibility, the net worth and number of employees of an applicant is calculated as of the date the proceeding was initiated. The net worth of an applicant is determined by generally accepted accounting principles.

(d) Whether an applicant who owns an unincorporated business will be considered as an "individual" or a "sole owner of an unincorporated business" will be determined by whether the applicant's participation in the proceeding is related primarily to individual interests or to business interests.

(e) The employees of an applicant include all those persons regularly providing services for remuneration for the applicant, under the applicant's direction and control. Part-time employees shall be included on a proportional basis.

(f) The net worth and number of employees of the applicant and all of its affiliates shall be aggregated to determine eligibility. Any individual, corporation or other entity that directly or indirectly controls or owns a majority of the voting shares or other interest of the applicant, or any corporation or other entity of

which the applicant directly or indirectly owns or controls a majority of the voting shares or other interest, will be considered an affiliate for purposes of this part, unless the adjudicative officer determines that such treatment would be unjust and contrary to the purposes of the Act in light of the actual relationship between the affiliated entities. In addition, the adjudicative officer may determine that financial relationships of the applicant other than those described in this paragraph constitute special circumstances that would make an award unjust.

(g) An applicant is not eligible if it appears from the facts and circumstances that it has participated in the proceedings only or primarily on behalf of other persons or entities that are ineligible.

---

45 C.F.R. § 13.5 Standards for awards.

(a) An award of fees and expenses may be made either on the basis that the Department's position in the proceeding was not substantially justified or on the basis that, in a proceeding to enforce compliance with a statutory or regulatory requirement, the Department's demand substantially exceeded the ultimate decision and was unreasonable when compared with that decision. These two bases are explained in greater detail in paragraphs (b) and (c) of this section.

(b) Awards where the Department's position was not substantially justified.

(1) Awards will be made on this basis only where the Department's position in the proceeding was not substantially justified. The Department's position includes, in addition to the position taken by the agency in the proceeding, the agency action or failure to act that was the basis for the proceeding. Whether the Department's position was substantially justified is to be determined on the basis of the administrative record as a whole. The fact that a party has prevailed in a proceeding does not create a presumption that the Department's position was not substantially justified. The burden of proof as to substantial justification is on the agency's litigating party, which may avoid an award by showing that its position was reasonable in law and fact.

(2) When two or more matters are joined together for one hearing, each of which could have been heard separately (without regard to laws or rules fixing a jurisdictional minimum amount for claims), and an applicant has prevailed with respect to one or several of the matters, an eligible applicant may receive an award for expenses associated only with the matters on which it prevailed if the Department's position on those matters was not substantially justified.

(3) Awards for fees and expenses incurred before the date on which a proceeding was initiated will be made only if the applicant can demonstrate that they were reasonably incurred in preparation for the proceeding.

(4) Awards will be reduced or denied if the applicant has unduly or unreasonably protracted the proceeding or if other special circumstances make an award unjust.

(c) Awards where the Department's demand was substantially excessive and unreasonable.

(1) Awards will be made on this basis only where the adversary adjudication arises from the Department's action to enforce a party's compliance with a statutory or regulatory requirement. An award may be made on this basis only if the Department's demand that led to the proceeding was substantially in excess of the ultimate decision in the proceeding, and that demand is unreasonable when compared with that decision, given all the facts and circumstances of the case.

(2) Any award made on this basis shall be limited to the fees and expenses that are primarily related to defending against the excessive nature of the demand. An award shall not include fees and expenses that are primarily related to defending against the merits of charges, or fees and expenses that are primarily related to defending against the portion of the demand that was not excessive, to the extent that these fees and expenses are distinguishable from the fees and expenses primarily related to defending against the excessive nature of the demand.

(3) Awards will be denied if the party has committed a willful violation of law or otherwise acted in bad faith, or if special circumstances make an award unjust.

---

45 C.F.R. § 13.6 Allowable fees and expenses.

(a) Awards will be limited to the rates customarily charged by persons engaged in the business of acting as attorneys, agents and expert witnesses. If a party has already received, or is eligible to receive, reimbursement for any expenses under another statutory provision or another program allowing reimbursement, its award under these rules must be reduced by the amount the prevailing party has already received, or is eligible to receive, from the Federal government.

(b) An award for the fees of an attorney or agent may not exceed $125.00 per hour, regardless of the actual rate charged by the attorney or agent. An award for the fees of an expert witness may not exceed the highest rate at which the Department pays expert witnesses, which is $24.09 per hour, regardless of the actual rates charged by the witness. These limits apply only to fees; an award may include the reasonable expenses of the attorney, agent, or witness as a separate item, if the attorney, agent or witness ordinarily charges separately for such expenses.

(c) In determining the reasonableness of the fees sought for attorneys, agents or expert witnesses, the adjudicative officer must consider factors bearing on the request, which include, but are not limited to:

> (1) If the attorney, agent or witness is in private practice, his or her customary fee for like services; if the attorney, agent or witness is an employee of the applicant, the fully allocated cost of service;

(2) The prevailing rate for similar services in the community in which the attorney, agent or witness ordinarily performs services;

(3) The time actually spent in the representation of the applicant;

(4) The time reasonably spent in light of the difficulty or complexity of the issues in the proceeding; and

(5) Such other factors as may bear on the value of the services provided.